National Cancer Control Programme

NCCP National PRRT Tumour conference - Standard Operating Procedure Guidance

Document control

Name of tumour conference:	National Peptide Receptor Radionuclide Therapy (PRRT) Tumour Conference			
Principal hospital:	St Vincent's University Hospital			
Day, time and frequency of meeting:	Fortnightly basis – 1st of 3rd Friday of the month			
Scope of meeting:	National	Hospital group	Other region/ group	Hospital specific
	✓			
Other hospitals involved in tumour conference:	Cork University Hospital Galway University Hospital			
Chair	Mathilde Colombié / Nicola Hughes			
Co-Chair/Deputy Chair	Hussein Almeamar / Mark Doherty / Dermot O'Toole / Donal O'Shea			
Last updated	December 2023			

Version	Date	Comment / Changes	Author	Reviewer
1	*19/11/ 2023*	*SOP first implemented at SVUH Hospital with effect from 23/01/2024*	*Mathilde Colombié*	

Executive summary

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Responsibility for the SOP	This document will be used by the NCCP National Clinical Leads Group For Neuro-Endocrine Tumours
Attendees	a. Consultant Nuclear Medicine Physician / Radiologist specialised in radionuclide therapy b. Consultant Neuroendocrine Tumours Physician c. Consultant Medical Oncologist d. Consultant Gastroenterology / Consultant Endocrinology e. PRRT CNM f. Medical Physicist g. Tumour conference coordinator h. Data manager i. Administrative support
Types of cases for discussion	a. Determining suitability for Lutathera b. Possible to relist a patient because of Lutathera side-effects, progression c. Possible to discuss the first post-therapy imaging evaluation
Data Template	PRRT referral form

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1.0 Introduction

1.1 Purpose of this document

The purpose of this document is to provide guidance for development of a standard operating procedure (SOP) for National Peptide Receptor Radionuclide Therapy (PRRT) Tumour Conference.
This guidance describes the process of registration, preparation, execution and documentation of the tumour conference.

1.2 Responsibility for the SOP

This National PRRT tumour conference SOP guidance document was developed by the National Cancer Control Programme (NCCP) National Clinical Leads Group for Neuro-Endocrine Tumours and will be reviewed periodically by the NCCP in line with national standards and international practice and updated/amended, as appropriate.

This document will be used by the NCCP National Clinical Leads Group for Neuro-Endocrine Tumours to create national tumour specific SOP guidance for tumour conferences. In cases where there are no NCCP Tumour Leads Groups for a particular tumour, hospitals should consider this generic guidance when developing an SOP for tumour conferences. Hospitals may incorporate their own processes where appropriate into the document in addition to the requirements as set out in this document.

All tumour conferences should have an SOP and should take into consideration the latest NCCP SOP for tumour conferences. Local tumour-specific SOP documents should be updated as required to agree any required amendments.

1.3 Definition of a tumour conference and multidisciplinary team

1.3.1 Tumour conference

The tumour conference involves a group of people from different health care disciplines, which meets together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the discussion on diagnosis and to make recommendations on patient management. It provides a forum for multidisciplinary teams to regularly convene and discuss the diagnosis and management of cancer patients.

1.3.2 Multidisciplinary team (MDT)

A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. doctors, nurses, psychologists, social workers, pharmacy etc.), each providing specific services to the patient. The team members independently treat various issues a patient may have, focusing on the issues in which they specialise. Members of the MDT include those listed as required and desirable attendees at the tumour conference (see section 3.0 Suggested membership of tumour conference).

The activities of the team are brought together using a care plan. Sometimes the patient has a member of the healthcare team, who becomes their main point of contact.

Communication between members of the MDT is key to providing quality care and improving patient outcomes. Activities of the team should also be brought together through annual quality assurance days and attendance at mortality and morbidity conferences.

2.0 Purpose of the tumour conference

An objective of the tumour conference is to ensure that all newly diagnosed cancer patients benefit from expert multidisciplinary evidence-based discussion of their diagnosis and management. Tumour conferences aim to ensure that all patients receive timely diagnosis, that patient management is evidence-based and that continuity of care is maintained.

All newly diagnosed cancer patients and those as outlined in 'Section 5.1 Types of cases for discussion' should be discussed in a tumour conference.

The National Clinical Leads Group for Neuro-Endocrine Tumours should identify a clear process for how patients should be identified.

2.1 Functions of the tumour conference

The function of the tumour conference should be explicitly reviewed and documented for each cancer/tumour type.

The function of the tumour conference includes:

a. To establish or confirm diagnosis, determine the extent and stage of patient's disease, review and resolve ambiguities and discuss its probable course
b. To record the clinical and pathological stage of the disease
c. To facilitate clinical, radiological and pathological correlation
d. To ensure prompt, effective multi-disciplinary decision making, thus preventing delays in the management of patients
e. To agree a recommendation on patient management
f. To provide a recommendation to the patient's Primary Consultant
g. To ensure the maintenance of clinical standards and protocols to support clinical governance
h. To plan or confirm evidence based management of each patient including referring to the appropriate tumour conference member or, if a second opinion is sought to recommend that the Primary Consultant or designated representative attend and present the case at the tumour conference or to refer to the appropriate specialist who will attend and discuss at a tumour conference as needed
i. To consider patient's other requirements such as palliative care or referral to other services
j. To ensure that mechanisms are in place to support enrolment of eligible patients into clinical trials and other research studies predicated on patients giving fully informed consent
k. To collect data to support the workings of the tumour conference
l. To collect data to aid audit or research
m. To collect data required for NCCP agreed data fields
n. To provide an opportunity for shared learning and development to all members of the multidisciplinary team and facilitate continuing professional education for all staff
o. To provide an opportunity for education and learning to its members and trainee doctors

3.0 Suggested membership of tumour conference

3.1 Required attendees

The list of required specialist attendees are detailed below. At least one representative from each of the specialties must attend each tumour conference. The NCCP national tumour specific tumour conference SOP guidance, once developed, will give more specific detail on attendees.

j. Consultant Nuclear Medicine Physician / Radiologist specialised in radionuclide therapy

k. Consultant Neuroendocrine Tumours Physician / Consultant Medical Oncologist / Consultant Gastroenterology / Consultant Endocrinology
l. PRRT CNM
m. Medical Physicist
n. Tumour conference coordinator
o. Data manager
p. Administrative support

The required attendees hold the responsibility for discussing the patients and making the recommendation on patient management. All required members will have a named designated representative who, will attend on their behalf, where appropriate, depending on the nature of the cases for discussion.

Section 4.0 Role and responsibilities of tumour conference members outlines the roles and responsibilities of the attendees at the tumour conference.

3.2 Desirable attendees

Desirable attendees are other members of the MDT who should attend the tumour conference at least once a year.

a. Consultants from other specialities
b. Pharmacy
c. Health and Social Care Professions (HSCP)
d. Clinical geneticist/genetic counsellor
e. Research staff e.g. nurses, data managers
f. Psychology
g. NCHDs in cancer service rotations

3.3 Guest attendees

Appropriate guests may attend with the approval of the Chair/Co-Chair and tumour conference, as relevant. Guests should be introduced to the team members and their attendance should be recorded in accordance with the SOP.

3.4 Record of attendance

Attendance at the tumour conference will be recorded for all required attendees. The system in place for recording attendance at the tumour conference is currently on W://PRRT folder in SVUH.

3.5 Quorum

This guidance document lays out the required attendees (see Section 3.1 Required attendees) to ensure a quorum for the tumour conference, it is the hospital's responsibility to ensure that the quorum is met and attendance of required consultant members is documented.

3.6 Attendance

Attendance for the quorum, by the required attendees, is expected for at least 75% of meetings. All members should have a named designated representative (consultant/specialist registrar) who will attend on their behalf when the Primary Consultant is unable to attend the tumour conference. The Chair should be informed of the attendance of a designated representative in advance of the meeting.

The Primary Consultant of the patients being discussed should be present. The tumour conference record should record the details of the consultant or designated representative who presented the case. Where

opinion is sought from specialist tumour conferences, a designated representative may present the patient's case at the tumour conference.

3.7 Shared tumour conferences

In the case of shared tumour conferences, where required attendees of the tumour conference are split across more than one site, the clinical governance of the tumour conference should be explicit and outlined in the SOP. The Chair of the shared tumour conference may rotate between sites.

4.0 Role and responsibilities of tumour conference members

4.1 Chair

The Chair should be a Consultant member who participates regularly in the tumour conference and is accountable to the hospital governance system. A Co-Chair should be appointed and take on the responsibilities of the Chair when the Chair is absent. The Chair may delegate/rotate the actual running of the tumour conference and other responsibilities.

All required tumour conference members will have a vote in the selection of the Chair and Co-Chair. The Chair position will be rotated on a regular basis to be determined locally, between interested candidates of the required disciplines.

The Chair is responsible for:

a. Facilitating participation by all members of the multidisciplinary team in clinical discussions and decision making
b. Verifying attendance at the tumour conference
c. Accurately identifying each patient being discussed using name and Date of Birth (DOB) and health care record number
d. Ensuring that all forwarded cases that have been selected for presentation are discussed within the allotted time. This may include direct entry of data on the tumour conference system
e. Inviting the referring clinician to summarise the case
f. Inviting review of pathology and radiology as appropriate
g. Inviting review of other disciplines as appropriate to the case e.g. radiology, palliative care
h. Encouraging participation of all tumour conference members and facilitating a team environment
i. Ensuring that patient confidentiality is maintained by reminding participants of privacy issues and permitting only appropriate attendance.
j. Summarising the recommendations of the meeting to ensure all parties are in agreement with the conclusion of the case
k. Ensuring that the recommendations of the meeting are made available to the members of the tumour conference in a timely fashion by delegation to the tumour conference coordinator

4.2 Required medical consultants

The Primary Consultant, under whom the patient is being cared for, remains responsible for the patient. For patients discussed at specialist tumour conference who are being seen at a linked hospital; the responsibility for the patient's care remains with the Primary Consultant in the linked hospital in such circumstances. The below responsibilities listed may be assigned by the patient's Primary Consultant to a named individual.

However, it remains the responsibility of the patient's Primary Consultant that such actions are carried out to their satisfaction.

Individual required medical consultants of the tumour conference are responsible for:

a. Informing the tumour conference coordinator of the patients for discussion by agreed advance deadline
b. Providing patient case summary to the tumour conference coordinator within the referral form by a week before the meeting
c. Providing the relevant patient information to the tumour conference coordinator, including radiology and pathology reports, and the specific issue to be discussed by the multidisciplinary team, prior to each meeting
d. Presenting the patient case at the tumour conference (or sending a delegate to present) and maintaining patient confidentiality
e. Providing expert opinion from their area of expertise
f. Discussing the treatment options and conclusions, as discussed at the tumour conference, with the patient and making the ultimate decision on patient management in collaboration with the patient
g. Entering the following details into the patient's medical record:
    i. The tumour conference recommendations within 24 hours of the tumour conference
    ii. The physician-patient discussion regarding the tumour conference recommendations
    iii. The patient's final decision about their management
    iv. In cases where the patient seeks a further opinion about the proposed management plan, the referral for second opinion should be documented in the clinical notes
h. Committing to attend (the majority or 75%) of tumour conference and to send all new cancer cases from their practice as well as any other cancer cases (e.g. recurrent cancer) that would benefit from discussion by the tumour conference
i. For cases submitted by a satellite hospital for discussion at the tumour conference, the Primary Consultant at that hospital must ensure that all required reports and materials are provided to the tumour conference coordinator in a timely manner

4.3 Tumour conference coordinator and Tumour conference data management

Ideally each tumour conference would have a person to manage the coordination in addition to the data management. Coordinators and data managers may manage more than one tumour conference as well as having varying roles depending on local arrangements. Some elements of these roles may also be undertaken by other designated members of the MDT.

Typical tasks in tumour conference coordination:

a. Keeping a record of attendance at meetings
b. The administrative management and individual meeting functioning
c. Preparing the register of patient cases for discussion at the meeting, based on cases forwarded by individual consultants in line with the conference SOP
d. Ensuring all up to date information including slides and imaging are available prior to the meeting
e. In the case of shared tumour conferences:
    - Liaising with Cork and Galway Hospitals regarding patients for tumour conference

- Integrating the Cork and Galway Hospitals tumour conference list in liaison with the coordinator in Cork and Galway Hospitals

f. Organising the meetings, book and set-up meeting room and required equipment.
g. Notifying required members and others
h. Contacting non-regular participants of the tumour conference when a patient case requires their review
i. Coordinating and distributing annual attendance records
j. Coordinating evaluations of the tumour conference meetings
k. Coordinating review of the SOP
l. Maintaining an up to date distribution list of tumour conference members and attendees, including those at satellite hospitals
m. Recording the outcome of the tumour conference on the tumour conference documentation system in line with local processes
n. Maintaining and follow up on action list, obtain updates from action owners
o. Coordinating and distributing annual attendance records
p. Managing the theatre case list for PRRT patients

To note: The tumour conference coordinator will not be responsible if the requested material is not provided by the referring unit. A designated representative should be assigned in case the coordinator is unavailable.

Typical tasks in tumour conference data management:

a. Collecting valid and accurate data in accordance with agreed local and national data sets and requirements
b. To keep up to date on the minimum data requirements as outlined by the tumour conference SOP
c. To collate data for presentation at relevant national audit quality review conferences
d. Support multidisciplinary teams to undertake ongoing audit and evaluation of the tumour conference
e. Ensure data are kept confidential and secure in accordance with local policy

5.0 Meeting Protocol

5.1 Types of cases for discussion

Validation of suitability (related to indications): Lutathera is currently licenced for the treatment of unresectable or metastatic, progressive, well-differentiated (G1 and G2), somatostatin receptor positive-gastroenteropancreatic neuroendocrine tumours (GEP-NETs) in adults. Other candidate patients for PRRT using radiolabelled somatostatin analogues include those with SSTR2-expressing NET of the bronchial tracts, phaeochromocytoma, paraganglioma, neuroblastoma or medullary thyroid carcinoma. Candidate patients for PRRT outside of current licencing require consensus agreement at PRRT MDT that on the basis of clinical assessment of the individual patient the MDT concludes that PRRT treatment is necessary to meet the individual needs of the patient. SSTR positivity must be confirmed on imaging.

Primary consultant can also relist the patient for discussion at PRRT MDT should the patient experience any treatment related side-effects that may require infusion schedule adjustment, dose adjustment or cessation of therapy.

The PRRT MDT is responsible for determining if the patient is suitable for Lutathera treatment. The PRRT MDT will also discuss the availability of treatment slots, whether patients can proceed to their next cycle, coordination of consultations and follow-up.

Formal validation of treatment is done by the radiologist/nuclear medicine physician specialised in radionuclide therapy after the consultation.

Possible discussion of the first post-therapy imaging evaluation (morphological imaging 3 monthts after Cycle 4)

The Primary Consultant or a designated representative must be present at the meeting for the discussion of their patients' cases.

All patients including those being treated through an agreed standard of care pathway should be registered at the tumour conference to facilitate their recording.

5.2 Registering patients for tumour conference

The process of registering patients for discussion at the tumour conference is agreed locally and in alignment with any nationally agreed referral pathways. Pathways are established with clear information on who can register, how to register and the acceptable times frames in which patients registered will be discussed.

Referring consultants are consultants in charge of neuroendocrine tumour patient care. Following discussion at the NET MDT, the NET consultant refers patients to the PRRT MDT by completing the PRRT referral form. When a patient is referred for PRRT from an external institution, the patient should be referred to a NET consultant from SVUH who will be designated to see and assess the patient in advance of PRRT, to follow and lead the care of the patient during the entire treatment cycle as outlined above and to communicate care to and arrange follow-up with the consultant from the external institution.

5.3 The conference time and venue

The National PRRT Tumour conference should convene at a specified date on a fortnightly basis - 1st or 3rd Friday of the month at 8:30am following the National NET Tumour Conference. Any change of time/date or venue will be notified by group email in advance. The conference must be held at least once a month.

To facilitate an efficient conference there should be appropriate equipment available in the tumour conference room e.g.

a. Projection equipment for displaying images and slides
b. Secure computer systems
c. Videoconferencing equipment
d. Teleconferencing equipment.
e. Information technology support
f. Any other items as required

Meetings should be face-to face wherever possible. Having a tumour conference that spans multiple hospitals will effectively use skills across the region. Participants from these hospitals should video link into the regularly scheduled tumour conference and present patients' cases, as appropriate.

5.4 Tumour conference data template

A tumour conference data template (PRRT Referral form) should set out the minimum data requirements to be recorded for each case discussed at the meeting. The tumour conference template should include both tumour specific and general data fields. Nationally agreed tumour specific data fields will be defined by the National Clinical Leads Group for Neuro-Endocrine Tumours; for tumours where there are currently no NCCP Tumour Leads Group hospitals should have an agreed template for their tumour conference.

The minimum data information requirements should be available as a paper template or made visible on an electronic tumour conference template.

Information necessary for effective team functioning and clinical decision-making will be provided/available prior to and during the meeting and reviewed by relevant members of the tumour conference in advance.

This should include:

a. A list of all cases for discussion including patient's name, date of birth and health care record number (Agenda)
b. The Primary Consultant or delegated representative should present the rationale for discussion and patient history
c. Patient-related staging information images (e.g. pathology, radiology) must be available at the conference and suitable technical equipment must be provided for the presentation of the visual material.
d. Patient views and preferences, if known
e. Other relevant reports and clinical information
f. The question being posed for the tumour conference

All cases for discussion at the tumour conference must be submitted to the tumour conference coordinator by one week before the meeting. Alternatively cases may be added by users to electronic systems as outlined in the relevant tumour conference SOP.

Cases will be ordered in a logical way on the agenda as designated by the chair.

Team members must be appropriately prepared for the tumour conference. Preparation for and attendance at tumour conference are recognised to be clinical commitments and time should be allocated accordingly.

5.6 Format of the meeting

5.6.1 Presentation

The Primary Consultant or the PRRT CNM will present the rationale for discussion and will give a short presentation on each patient. Radiology, histology and other reports, as relevant, will be presented, as appropriate.

5.6.2 Discussion

Discussion of the case can include:

a. Diagnosis and staging information
b. The proposed management plan for the patient
c. The care pathway for the patient
d. The location(s) for receipt of treatment
e. Any specific information and support requirements for the patient
f. Consideration of the patient's holistic needs
g. The Primary Consultant
h. Any required referrals
i. Shared care arrangements between departments and between centres
j. Indication for re-referral to the tumour conference
k. Frequency for re-referral to the tumour conference
l. Specific discussions around radiation safety
m. Specific discussion at the initial phase about who will be treated at SVUH and who will be treated via TAS

5.6.3 Outcome of the conference

a. Agree and document the management recommendations made for each patient.
b. Agree further investigations required.
c. Agree which patient should be offered entry to approved clinical trials.
d. Refer patients as appropriate for treatment as appropriate e.g. radiotherapy
e. Document all information including the recommended management plan for each patient.
f. The patient's Primary Consultant is responsible for ensuring that a letter is sent to the patient's GP with details of the management plan for the patient.
g. Document all required datasets (e.g. to inform KPIs, audit etc.)

Any substantial deviation from the management plan by the Primary Consultant should be documented in the patient's notes and discussed at tumour conference, where appropriate.

Any substantial deviation from national clinical guideline recommendations should be documented in the patient notes and discussed at tumour conference where appropriate.

5.6.4 Management plan recommendations

Management plan recommendations within the tumour conference will be handled as follows:

a. The specific evidence basis for possible treatment options will be discussed and recorded at meetings.
b. The majority of the group will be taken as the consensus for the record.
c. Where multiple reasonable options are available and each is supported by more than one consultant, a summary of the potential options will be recorded for discussion with the patient

On request, the patient will be provided with the following documents:

a. Tumour conference protocol/management plan
b. Medical report/discharge letter
c. If relevant, study documentation

The specific evidence base for treatment options should be discussed and recorded at meetings including any national clinical guideline recommendations. Any deviation and justification from national clinical guideline recommendations should be recorded.

5.6.5 After the tumour conference

The completed tumour conference data template must be approved by the conference Chair and must be available for reference in management of the patients care.

Recommendations made at tumour conference will be made available to all members within 24 hours of the tumour conference and they will be included in the patient record, as per local hospital policy. Recommendations made at tumour conference will be copied to the patient's GP as well as the referring consultant as appropriate.

6.0 Record of the meeting

There should be an agreed template at tumour conference for all patients being discussed including those that are managed through a standard of care algorithm. Standard of care algorithms should be agreed at a National level.

The record of the meeting will include the following minimum details as relevant:

a. Personal details

b. Assessment procedure
c. Clinical assessment
d. Imaging assessment
e. Histology assessment
f. Staging
g. Patient management plan
h. Concordance / discordance / missing data

6.1 Record maintenance

Details of the tumour conference will be recorded by:

a. Using a tumour conference documentation system (where paper is in use for record maintenance a tumour conference template should be agreed and in use).
b. Records of the tumour conference register and outcomes must be securely stored and available for review including in the patient record within 24 hours of the conference concluding.
c. Any deviation by the consultant from the recommendation of the tumour conference (including those made at the choice of the patient) should be documented at the tumour conference.

7.0 Urgent case process

In cases where an urgent case arises which cannot wait until the next scheduled tumour conference, the Primary Consultant will discuss the case with colleagues, as appropriate. The case should be brought to the tumour conference for subsequent discussion and/or refinement of the patient management plan where the patient meets the criteria as defined in Section 5.1 Types of cases for discussion.

8.0 Patient engagement

Patients should be informed about the tumour conference, the discussion of their case at the tumour conference and the recommended patient management plan.

The patient will make the ultimate decision about their treatment from the options recommended

9.0 Patient confidentiality

Confidentiality of patients' information is paramount. All attendees should be aware of the local data protection policy and make all reasonable efforts to ensure patients' confidentiality. All attendees must discard any printed patient information securely following from the meeting e.g. shredding, confidential bins etc. Any attendee retaining documentation from the tumour conference is responsible for maintaining the confidentiality of the documentation.

10.0 Audit

The tumour conference will agree and indicate here an appropriate approach to audit of conferences and cases.

Measure of success

a. Attendance records
b. Proportion of patient cases discussed at tumour conference of total possible patient cases.
c. Proportion of patients following the tumour conference recommended patient management plan vs another management plan and reason (Primary Consultant plan, patient wishes etc.)
d. Proportion of patients discussed with a recommendation recorded
e. Proportion of recommendations available in the patients notes within 24 hours of the tumour conference

f. Time in implementing treatment recommendation
g. Tumour conference member satisfaction survey
h. Morbidity and mortality discussion

11.0 Tumour conference evaluation

The tumour conference will be evaluated annually or as frequently as felt necessary by the team members. The tumour conference coordinator will distribute evaluation forms to all members to complete. The forms will evaluate meeting effectiveness, strengths and weaknesses. Specific roles may also be evaluated such as the Chair and coordinator to determine what is working well and what could be improved.

The evaluation forms will be collected and the results will be summarized. The results will be discussed with the MDT to come to consensus on how the tumour conference could be improved based on the feedback. The appropriate actions will take place to implement the desired changes which may include updating the SOP document.

12.0 Annual report

The tumour conference will agree and indicate an appropriate approach to the development of an annual report detailing useful statistics on tumour conferences and the development of the service.

Appendix 1 Glossary

Chair	A consultant member who participates regularly in the tumour conference and who is accountable to the hospital governance system.
Primary Consultant	The Primary Consultant of a case is the consultant who has overall responsibility for the case. (HIPE Data Dictionary 2022)