The Royal College of Pathologists
Pathology: the science behind the cure

11 November 2021

Working Group on Cancer Services

A meeting of the Working Group on Cancer Services was held on 11 November 2021 at 11am using Zoom.

Dr Lance Sandle
Registrar

Confirmed minutes

Present:	Dr Michael Eden (ME) Prof Keith Hunter (KH) Prof Sebastian Brandner (SB) Dr Newton Wong (NW) Dr Paul Craig (PC) Dr Guy Martland (GM)	Chair Elected member Elected member Elected member Co-opted member - British Division of the International Academy of Pathology (BDIAP) Co-opted member - Association of Clinical Pathologists (ACP)
In attendance:	Maria Marrero Feo (MMF) Katherine Timms (KT)	Clinical Effectiveness Manager Director of Professionalism
Apologies for absence:	Dr Muhammad Shafiq Gill (MSG)	Elected member
Declaration of conflict of interest – No declarations of interest were made.		

WG. 28/21 Minutes of the meeting held on 11 June 2021

The minutes were accepted as a correct record of the meeting.

WG. 29/21 Actions from the meeting held on 11 June 2021

(a) WG.09/20 (a) KPI criteria for audits/standardised for datasets
Update: SB commented that consideration be given to combining the two documents if the quality and information content is minimal. PC added that both have the same guidelines; different Trusts interpret the same workload document in different ways.

PC expressed concern that the document stated that the guidelines were only relevant if there was adequate staffing and resourcing in place. This helped provide an argument to put to management for additional resources.

There was a risk with including reference to molecular testing. Removing this reference would not force the issue on the Genomic labs hubs and Genomic and NHS England to resolve. It works both ways.

ME referred to the section on NHSI Pathology Quality Assurance Dashboard in the document. He mentioned that some of the items did not make sense, with a few items being slightly ambiguous and he cited some examples.

SB noted that guideline documents should have clearly understandable numbers, which was not currently the case. Everyone agreed that reference to numbers provided by the commissioner was not acceptable.

Actions: ME to review the KPI document with the inclusions of the notes discussed at the meeting and attempt to integrate the key assurance indicator document into this KPI document.

MMF confirmed that the consultation of the KPI document had been paused but we should need to integrate that as well.

(b) WG.25/20 ii) TAB specimens survey

Update: SB informed the group that he had not done the survey as it will be carried out by someone else. It was agreed that this would be a separate new tissue pathway / dataset. For now, Temporal Artery Biopsies were part of the Neuropathology dataset: Tissue pathways for non-neoplastic neuropathology specimens. It was considered that TAB was sufficiently distinct to warrant a separate document. SB was invited to lead on this but had declined as it was not his area of expertise. The author would be Dr E Tasha, Clinical Research Fellow at Leeds.

Actions: SB to send email trail to ME.

(c) WG.25/20 vii) MDT guidance

Update: draft not yet received.

Action: MMF to share draft with group once received.

(d) WG.25/20 viii) Recruitment for new working group members in light of the criteria and wording for diversity and inclusion.

Update: ME mentioned that MMF had updated him regarding the advert. MMF commented that it had proven difficult to recruit to the vacant positions. The advert had been published twice, plus emails had been sent to the College membership and it had been tweeted weekly. The deadline had been extended several times and the new closing date was 19 November. There had been only one application received. MMF requested that the group email their colleagues. There were three vacancies: two new members and a replacement. In addition, ME would draft an email reminder for the membership, outlining the benefits and perks of the role to encourage responses.

Action: ME to draft email reminder for the membership, outlining benefits and perks of the role.

WG.30/21 Matters arising from the meeting of 11th June 2021

i) Implementation of the National Genomic Test Directory for Cancer

ME mentioned that discussions were ongoing between the RCP and NHS England regarding the roll out of NGS testing. WGF Testing and how much pathology is recorded in the Test directory for Cancer.

The September meeting with Mike Osbourne and Sue Hill discussed what the role of the College would be in terms of WGF Testing for all cancers nationally. A proposal had been drafted and was shared with the group. This included a summary of the membership survey that was circulated. The key messages were:

- **only 3%** of histopathology departments' have enough staff to meet clinical demand.
- **2/3** of members were taking on **pro bono work** to help report genomic tests.
- Half indicated that they had not received sufficient training and half had not accessed the Test Directory for Cancer.
- 1/3rd reported that they perform genetic tests on all samples.
- The consensus was that ¾ of pathology departments required additional staff.

A plan had been drafted to increase medical and scientific resources for preparing tumours for genic testing.

Domain 1. **Increased medical and Scientific work to prepare tumours for genic testing**.
Pilot site testing – for fresh pathways including large university labs and small DGH labs to test pathways.
Genetic Testing Tariff – funding to go to Histopathology labs per case sent for genetic testing. This to cover the extra resources required to prepare and submit material for testing.

Domain 2. Education/Engagement with Histopathologists.
Ensure there is RCPath representation at the National Directory Steering Group.
Mutual recognition of the RCPath Cancer Datasets and National Test Directory.

Domain 3. Complexity of genetic test reports.
Fund the integration of genetic reporting into medical staff jobs (e.g joint sessions between Cellular Pathology and genomic medicine services).
Explore the merging of GLH and histopathologist laboratories to form Histo-Genomic Centres – will combine the genetic and tissue expertise into comprehensive cancer genetic services.

ME commented that Mike Osborn had presented this information at the meeting. Sue Hill, Chief Scientific Officer, had reacted positively to the proposals, to such an extent that she suggested setting up a Task and Finish Group to take these plans forward. It was a significant and positive outcome.

The Task and Finish Group would be co-chaired by Mike Osborn and Sue Hill. Following discussions between ME and Sue Hill's deputy, the membership was to include:

- a WGCS rep
- IBMS rep
- Genomics & Reproductive Science SAC rep

Additional membership to be decided by co-chairs and included in the Terms of Reference for the Group.

It was acknowledged that there was a balance to be struck between the size of the Group and its efficiency; the deadline for all outcomes to be met was the end of the current financial year.

Action: ME to update on the Task and Finish Group at next meeting.

KH commented that this was good progress. On a related matter, at the Cellular Pathology SAC meeting the previous week, it was suggested that there be a link to the National Geonomics Testing Panel to ensure that it is embedded into all datasets.

Before leaving Geonomics NW asked to discuss Blocked Key suggestions under AOB. The Group agreed. He thought there was an initiative for any new datasets to include a molecular block, nominate molecular block key as well as a nominator block for non-neoplastic tissue. Obviously, to make the Audit Team's lives easier, when getting a request for molecular testing it would be worth including, (this may or may not be contentious) a statement whether the molecular block contained more or less than 20% neoplastic cell content, as that was the threshold which tended to be used for most testing. As there is a block here saying more that 20% then, in theory, once the request comes in all the Audit Team have to do with the main labs is cut curls from that block and send them off. NW had sent a version of what he had put on an evolved GI dataset to ME; he was happy for the group to look at it.

ME queried other criteria, as often a request for percentage of necrosis was received as well. NW replied that, for WGS a 20% necrosis factor was used for the standard of care testing, which used the SRTS0500 panel as well as more basic tests. There was not a formal threshold for necrosis, as far as he was aware, although he was happy to be corrected if this was wrong. On the request form for genomic testing of tissue there was no necrosis box to tick. Perhaps others were more cautious. SB recalled having a box to tick, but always sent an adjacent H&E and a consultant marked the area that needed to be extracted at their end. This meant that he would send five unstained sections plus an adjacent section and that would be for both the DNA, NGS, RNAC sequencing for fusions etc. NW asked if SB commented on the percentage of necrosis, to which SB replied that they excluded necrosis. There was a tick box on the request form for The Royal Marsden. SB confirmed that necrosis was mentioned but would need to check whether the form asked for percentages. They mitigated the problem by giving an outline, which should be best practice. The recipient team could not always identify the cancer easily.

Regarding resourcing, SB wished to raise two issues. Firstly, 1PA per specialty may or may not be sufficient depending upon the scale of the operation e.g at his workplace, there was a total of 36 PAs consultants, 6PA for molecular reporting, which was very tight, and they may need to increase the PAs as the workload was increasing exponentially with the molecular test and the reporting of the test when returned. SB believed 1PA per consultant per specialty might be a very conservative estimate, depending upon how molecular heavy a specialty might be.

Secondly, SB enquired how the money would go to the department. ME replied that this would be decided at the top level. There were two options: either it would be paid directly from the NHS to individual histopathology labs or the NHS would pay the GLHs to be paid out to the relevant laboratories.

SB was concerned that the funding would not arrive where it was needed, the histopathology department. This was similar to the £40 per case paid for NGS testing. This would not include the reporting, just the technical workup and the filling of the form. ME concurred as it was not £40 per case. The initial money was intended to be £2.6 million regardless of the number of cases being done in the first year.

SB made another comment on the whole genomic sequencing, asking how much sense it made to do whole genomic sequencing on these cancers. He suggested instead using panel sequencing (leaving out metho as it was very much neuropathology/soft tissue). Was the benefit of having whole genomic sequencing that it would catch fussures, why not NGS?

ME thought there was a political driver as to whether NGS or WGS was better in the clinical context. The issue was that we are fighting against the political current**.** Which is that WGF is better than NGF And WGF is going to be… SB queried who would be looking at the data and all the non-coding areas. What was the variant? How was it going to be reported? Where was the data going to be shared and evaluated? ME responded that this was why the WGCS needed to be represented on the Task and Finish group with Sue Hill and Mike Osbourne. These were the sort of issues that needed to be raised. NW asked who was going to set up the fresh Frozen pathways to accommodate the WGS pathways. ME confirmed that this had been raised with Sue Hill already and she had indicated that it needed to be resourced appropriately.

SB mentioned that another challenge was the resource of histopathology hubs that were established 2-3 years ago. SB did not know where this went for the 27 hubs across all of England and that meant the material was shipped informally. Which means that frozen material was not always possible the way the pathways were created. ME had raised that and told them they ought to include NHS Improvement in this group as there was no point agreeing something and then NHS Improvement have agreed centralising of the pathology services, which may not sit with that vision.

PC considered it to be excellent news about the funding and the PA needed to be looked at. This was potentially revolutionary for the whole specialty. Looking back at the October 2020 Diagnostics: Recovery and Renewal, Report of the Independent Review of Diagnostic Services for NHS England, it included endoscopy, radiology and histopathology. Quote from document: *"Commissioning for Diagnostics: During this review, clinicians and managers working in NHS trusts frequently commented that the commissioning arrangements for different diagnostic tests can be a barrier to investment and reform of services. The costs of diagnostics are frequently bundled with outpatient or inpatient tariffs. This provides little incentive for trusts to invest in diagnostics or to replace ageing equipment. However, it is beyond the scope of this review to determine NHS commissioning arrangements. Separate commissioning arrangements are in place for genomics testing services and clinical genetics services.*

Recommendation 23: NHS England and NHS Improvement should review commissioning levers for diagnostics, to include tariffs, contracting arrangements, service specifications and quality requirements, to ensure that incentives are aligned with strategy."

ME commented that the indication from the meeting was that Sue Hill understood all the issues that were raised. Sue was adamant that, in terms of time frames, it needed to be completed sooner than later and needed to be resourced appropriately to address those issues. Mike Osborn made it clear that the College would be in a very good position to advise on how best to address issues if appropriate resources were in place.

So this returned to the point about why NGS or WGS. Even though correct, it would not be possible to win the argument with NHSE. They wanted to use WGS on everything and it was understood that they had signed a contract with suppliers already to do it.

Instead, the College would seek the best resources possible for the membership in the histopathology labs, in order to make a success of it.

PC advised that this needed to be included in all the datasets as a separate item.

SB wondered whether, in discussion with NHS England or Synchronising and technology, Nanopore Technology had been mentioned. This had potential and was being established in his lab. It could do combined mutations. It was a very complicated pipeline and it took about 3-4 years to set up. It would require a lot of resources particularly bio-computing and software. This was a great technology; however, it did not do whole genome sequencing, not at the depth of current whole genome sequencing. It would end up essentially as glorified panna sequencing, you have to limit Bio-metric tools, so limits numbers of targets. So, the 0.05 for the whole genome, was not going to be the same as we understand, it might be very useful. But again, for different cancers, may need different programmes and a different platform development. If it is Nanopore that is an interesting development. SB asked ME to confirm if they have already signed. ME confirmed it was possible to find online (publicly accessible) that the contract had been signed in April.

Action: ME to circulate Diagnostics: Recovery and Renewal report to the Group.

ii) Masterclasses to be provided by the writers of new/updated datasets at the time of publication (Webinar programme)
Update: these masterclasses were in progress. All authors of guidelines ready for publication have been approached, and webinars were in development.

iii) MDT guidance – Item covered in WG.29/20.

iv) Membership and Terms of Reference
Update: a) The group had previously proposed inviting applications from members of the devolved nations. Obtaining any applications had proved to be challenging. It was suggested that the group seek alternative ways of obtaining input into NHS England, Scotland, Northern Ireland, and Wales. The group required something similar for NHS Scotland, Wales and Northern Ireland to the current system in place to contact NHS England and communicate any issues that the group has. The group agreed.

b) KH and ME's three-year term of office were complete. Both were asked and agreed to extend for two years.

c) PC asked if diversity needed to be explored regarding the membership of this group, to ensure that the group complied with College policy. KT suggested that the two new co-opted Trustees could be invited to join the group. KT would send the details to ME for consideration. ME, mindful that the group had not received many applications to join, suggested that the group was aiming for meritocracy rather than advocating positive discrimination. PC clarified that he was recommending that the group should document that it was complying with the College Polices.

d) ME asked what practical difference this might make to the group. MMF explained that this issue was raised at the last meeting due to the College working towards improving diversity in all committees. The main consideration for the group would relate to how it engages with authors on clinical guidelines e.g. transparency in the selection process of authorship. It was suggested that something be published on the College website by the group, explaining the process for members who wish to apply to become authors.

SB mentioned that he was keen to attract authors to help with the guideline on which he was leading; he had found it difficult to attract a diverse group of people. He had attended a webinar where the audience complained that authors appeared to work in a few dominant centres. However, when adverts seeking new authors

are sent out and it entailed writing complicated chapters in guidelines (Neuropathology was mentioned), it proved difficult to find anyone willing to volunteer. In principle, anyone could apply. There was no reliable mechanism for engaging people; someone with an in-depth knowledge of the subject area was required, which meant that there may only be 2-3 centres with specific expertise e.g. paediatric muscle, and the authorship would be split between these centres.

Although the person leading on a cancer dataset could co-opt anyone they chose, they required colleagues who were not only qualified but willing to contribute constructively. There needed to be a degree of pragmatism; to avoid wasting time, it was inadvisable to have two strong personalities that would clash and be unable to agree on a final dataset.

MMF suggested that more transparency was required in the group's process of recruiting an author. SB proposed that an option would be for those applying for the role to provide evidence of previous work, plus a briefing of how they planned to lead the writing and what their qualifications were to lead. MMF expressed concern that the process could be lengthy and put pressure on those applying. SB commented that those seeking to be authors needed to demonstrate their willingness to invest time and resources, and the first hurdle to overcome would be the application process. In the past, some authors had not delivered what they had promised, or they had written unsuitable guidelines (not College guidelines). MMF suggested mentioning in the advert that authors who did not deliver the guidelines would be asked to step down and allow others to lead. KH recalled an example when an email was sent to members of the Head and Neck EQA with a request to deliver a brief statement explaining why they wanted the role. A broad range of responses was received from the very experienced to those just beginning.

It was proposed that trainees be involved, to act in a supportive role (administration, etc.). KH mentioned that they did not usually involve trainees as they had sufficient consultants. There had been some discussion for a senior author and trainee, however this was not felt to be appropriate. PC thought this had potential but, without having experience of the specialty, it was advisable to have at least two consultants. MMF clarified that the role of the trainee would be to provide admin support to the consultants, rather than to co-author.

Action: MMF to draft policy on the process for the group to recruit lead and co-authors.

NW gave his apologies as he had to leave the meeting early.

v) TAB specimens survey – As discussed in action (WG.28.21(b))

vi) KPI criteria for audits/standardised for datasets – as discussed in action (WG.28/21 (a))

vii) Revise paper – Computerised cancer histopathology reporting, data recording and downloading to cancer registries

MMF commented that the document is on the website and she will send the document to ME.

Action: MMF to resend paper and action for next meeting

viii) MoUs between the College/ICCR and College/IARC

MMF confirmed that these were completed. ME mentioned that Ian Cree, head of WHO editorial board, will be co-opted as a member of the working group and that a reciprocal member would be co-opted to the WHO editorial board. ME asked if there were any strong views on who should be co-opted. PC thought that ME was

the obvious choice. ME confirmed that Brian also sat on the editorial group. ME volunteered to take on the role, at least for the first meeting due in April/May 2022. PC thought that sensible and left the option for ME to offer it to the rest of the group if he had too high a workload.

ix) Author guidance on writing guidelines

SB suggested that drafts be circulated on Sharepoint or One Drive to avoid having multiple copies circulating at the same time. A single document with a hyperlink was more suitable. He asked MMF to check with College IT for feasibility. The group considered that, as the content was not controversial or confidential, it should be possible to share it; all that was required was permission to share within a certain domain. Sharepoint was considered the better option as it worked with Microsoft Word and worked well locally. MMF explained that currently there were issues with IT in the College, which were being worked on and hopefully this option would be in place for the next guidelines. SB mentioned that the setting should allow everyone to track changes. PC requested that instructions be drafted by IT in case people had issues with local firewalls. The group encouraged to work online to prevent people being blocked. GM suggested that the process be trialled prior to launch. The group agreed that this was a good idea.

x) Diversity and inclusion paper – discussed earlier.

WG. 31/21 COSD report

ME reported that the roll out of version 10 has been postponed for 12 months. This was due in part to the Cancer Registry being transferred from PHE, which had been disbanded, into NHS Digital. There was nothing to affect the group in the immediate future.

WG. 32/21 Report on ICCR activity

SB reported on ICCR activity **(report appended to the minutes as APPENDIX A)** Brain Tumour updated that they are drafting proposals for testing. There was a European initiative for a guide for best practice testing. SB had mentioned that the ICCR were potentially in sync with the Blue Book publication. When ME met Ian Cree, a few months ago, ME mentioned that it would potentially be very helpful for the College to do the same for its datasets. Ian Cree was happy with the idea of WHO sharing the published schedules with the College to align the timeline accordingly. ME asked MMF whether there was any reason why the College could not align with the Blue Book schedule, when they had the meeting with the representative of NICE. MMF replied that Deborah Collins was going to come back to ME on the question but had not yet done so.

Action for MMF/ME to chase up Deborah Collins.

WG. 33/21 Progress on datasets

- Breast dataset – MMF had met with Rahul, who was not happy with the level of admin work. Rahul had sent MMF the different sections and she will put the document together and follow up with a meeting with Rahul.
- Soft tissue sarcomas – Draft has been sent to MMF alongside the audit. MMF had not been able to do it yet due to workload but hopefully, with new staff coming on board, will be able to do. PC had looked through and made comments on the paper version but was not sure if it had been sent to MMF. MMF confirmed that she had not received it yet so PC would send it through and MMF will verify before sending it to Mike.
- Endocrine system (Thyroid, Parathyroid and Adult adrenal gland) – MMF mentioned that the thyroid letters were sent on 30 September. She was following up with reminders. Parathyroid letters were sent in September on the progress of

the work. Adult Adrenal received a receipt of confirmation which needed to be followed up. ME offered to chase up Alison Marker and PC offered to chase Thomas Papathomas.

- Conjunctival melanoma – MMF to draft expected next year.
- Retinoblastoma – MMF had mailed the lead author and was awaiting a response, will follow up.
- Uveal melanoma – MMF commented that the final draft needs to be reviewed before sending to publication.
- IBD dataset – MMF had sent letters to authors in September. Trying to set up a team but no response yet.
- Barrett's oesophagus – MMF requested more consideration on this. They will come back to us, needs follow up.
- Colorectal – MMF hoped to get draft before Christmas very unlikely that will be this year.
- Liver – ME commented that mapping of tables needs to be done.
- Anal cancers – MMF reported that follow up needed, reminder sent in October.
- Vulval – MMF mentioned that this was on hold pending. Waiting for responses. PC thought it had not really been incorporated and suggested everyone should have a look before spending much time on it. Lead author had shared version 6 with Brian Rous/Cheryl and ME. Cheryl (who had left) had not sent the email to MMF. PC had not received version 6 so MMF will send. MMF planned to create a new email inbox for NICE clinical guidelines to prevent issues if staff leave, avoiding MMF being out of the loop in future
- Endometrium – MMF reported that a draft was expected in November, needs follow up.
- Uterine sarcoma – MMF reported that ICCR have published, authors working on the guidelines.
- Carcinomas of nasopharynx and oropharynx – KH reported that it was with the publishing team, initial feedback from the Devolved nations was that they needed more time and had been given 2 more weeks. Comments were minor tidying and tightening up. Comments to be incorporated when everything was back.
- Carcinomas of the oral cavity – advanced draft on target for Christmas.
- Carcinomas of the hypopharynx, larynx and trachea – draft end of the year maybe early next year.
- Carcinomas of the nasal cavity and paranasal sinuses – Amrita Jayis the lead in London and working on it.
- Nodal excisions and neck dissection specimens – ongoing.
- Carcinomas of major salivary glands – was in discussion, which needed resolution. Some people were not delivering. Encouragement was needed on it, possibly leave until the Blue Book was published.
- Mucosal Malignancies of the Pharynx - Not directly going to review. KH confirmed with MMF that one will be ready, possibly one more but not all five at the same time. PC commented that if they were published one a month that would be better. KH also feels that will be the case and a good way forward.
- Malignant odontogenic tumours – Parking until others done
- Ear and temporal bone tumours- Parking until others done
- Mucosal melanomas of the head and neck – Parking until others done

- Lung (Lung, TETs and mesothelioma) – follow up needed with Professor Nicholson, ME would chase up; letter had been sent that needed a follow up. Expected by the end of the year.
- Peripheral neuroplastic tumours – Lead wants to discuss with co-authors for a full review and follow up wanted, not clear on title.
- Renal tumours in childhood – Follow up (again not clear on title).
- Germ cell tumours – New
- Lymphoma – MMF reported that this had been delayed while seeking authors. ME to send an email. ME informed the group that essentially the Blue Book for Haematological Malignancies was in the process of being discussed and put together. There was a political element to this and there was a potential splinter /breakaway group who wanted to diverge from WHO. It had become very political and, until this was resolved, the authors were not altering any datasets. MMF asked if this meant that there would be no progress with these guidelines, as it might take a year until the issue was resolved. ME confirmed that was correct. MMF remonstrated that it was very important to have up to date guidelines, yet these guidelines were published in 2015.

  SB considered this and probably a few other guidelines were outdated and probably superseded by two WHO classifications. This raised the risk that individuals would follow the guidelines and be inconsistent with WHO classifications and other more recent guidelines. He suggested removing the guidelines from the College website until they had been updated. This would avoid putting the College at risk of publishing outdated guidelines. ME agreed in principle but wondered whether authors of the dataset might have a view, perhaps considering that it was not particularly risky. SB suggested it would mitigate any risk of conflict. SB had no expertise on hematopathology, and queried whether there was any diagnostic, prognostic or therapeutic impact on using old guidelines versus 2016 or 2020 or even more recent haematology WHO publications. It was probably outdated in some respects. SB imagined there could be a medico-legal case in which a patient stated that they had had incorrect treatment or the way a procedure had been done could be legally challenged. If the pathologist replied that they had followed College guidelines, theoretically the College could be liable. If the guidelines were removed from the website, this would be mitigation. ME replied that, if an individual followed College guidelines, they were practising to agreed standards and *vice versa* if they did not follow the guideline to the letter it did not mean that they were guilty of malpractice. As a suitable compromise, MMF suggested that the College add a statement to the website noting that the guidelines were not accurate. SB asked whether the College should be publishing guidelines that were not accurate. ME thought it advisable to ask the lead authors for their opinion and act accordingly.

  MMF enquired how the College could support those who wished to use the guidelines, e.g. trainees. SB considered that using outdated guidelines which did not reflect current diagnostic reality, may be useful only for cut up and sampling but not for diagnostics. ME commented that, in this instance, it was somewhat out of the authors team's hands until this was resolved on an International level, rather than national reporting levels. Essentially there was a disagreement nationally as to what classification should be. This had led to a group of pathologists threatening to set up their own classification separate from WHO. SB noted that was comparable to Pituitary and Endocrine, which had a similar dispute. ME considered it was a reasonable compromise to approach the lead author in the first instance. If no response was received, the guidelines should be removed from the website. SB suggested that a good guideline could highlight the different opinions available and different classification schemes. There may be no actual consensus, this being

a matter of debate and showing the main viewpoints. It would be very helpful to trainees. ME responded that the issue was that they did not have two separate classifications at the moment and, reading between the lines, the threat of separate classifications systems was being used as leverage against WHO.

Actions: Lymphoma - ME contact Stefan and default to removing guideline from website.

- Cutaneous lymphoma – was in development and needed to be followed up. Needed to be reviewed and signed off.
- Penis – Delayed, pending publication of the WHO book, which was not out yet.
- Adult kidney – Deadline has been extended.
- Urinary collecting system – Getting ready for publication.
- Prostate – Delayed, waiting for the Blue Book; expecting it in 2022.
- Carcinoma of unknown primary – This had taken years to develop. Hoped to receive something early in 2022.

WG. 34/21 Progress on tissue pathways

Bone and soft tissue – Sent to the WGCS and to the lay group. Fresh paths have Sbeen completed. Need follow up as sent in September.

- GI – The lead is assembling the writing group.
- Head and neck – Sent for review on 6 October, not completed. Need to follow up.
- Dermatopathology – Followed up in July. Need to see who is going to take this on. MMF let the group know that Ashok Bansal was stepping down and a replacement was needed. PC commented that, although this is the largest number of datasets, from the patients' point of view there is nothing important in there that needs to be changed.
- Gynaecological – MMF needed to contact Raji to respond to a message left. ME offered to follow up with emails if authors were not responding.

WG.35/21 Any other business

i) Legal framework or professional guidance to request diagnostic tests directly from a laboratory and have the results returned to them directly: for example, a check for STIs (microbiology) or a screen for anaemia(haematology) or thyroid function tests (clinical chemistry)

Following group discussion, SB questioned the reason for the query.

Action: MMF to send the email to SB for consideration.

ii) Histopathology BMS reporting

ME mentioned the proposal of a formal qualification for Advanced BMS Practioners to report in Histopathology. Some concerns had been expressed regarding a lack of consultation with the College and how this role fitted with the workforce requirements in the next five, ten and fifteen years. ME invited comments from the group about being assisted with histopathology reporting. Were there more opportunities in Molecular pathology? With AI assisting, there could be fewer opportunities for BMS staff to do reporting.

PC asked whether it was specialty specific. He reported that the Dermatopathology subgroup of the British Association of Dermatopathologists had received an overwhelming response to a recent survey which indicated that most members were against Advanced BMS Practioners reporting. The pervading view from most

specialist Dermatopathologists was that the College had promoted this initiative and the consensus was the opposite of what the College had been seeking. Outside Dermatopathology the views were slightly different. Some BMSs had been trained up in PC's department. Neil Shepherd has accepted it for normal GI testing. A proper survey from the College to elicit opinions was required. PC considered that there was not a problem with training but there was limited time to train two different groups.

GM commented that he had experience of BMS trainees going through the scheme, with some on the GI path and others on the Gynae path. Some who had followed the GI path were not actually reporting but had used it as a route to doing more advanced cut up. BMS Advanced Practioners doing cut up was considered beneficial as it relieved the burden on consultants. However, concern was expressed regarding their reporting of specimens; there were currently sufficient challenges with SAS Doctors reporting specimens.

KH did not have direct experience of BMS trainees. He had received an email regarding this. Adrian Bateman, Chair of the Cellular Pathology SAC and KH had sought a wider exploration of the issues. A document was produced and sent to the SAC specifying several areas of concern. Mike Osborn, Adrian Bateman and KH had intended discussing this ahead of the last SAC meeting but Mike Osborn's diary did not allow for this. KH was uncertain what agreements were made at the SAC meeting. His view, given the seriousness of the issues, was that there probably needed to be an overall review of this. He had received the impression that the SAC's view was to acknowledge concerns but keep calm and carry on. This was not considered to be a helpful approach, given the significant concerns of the profession.

KH was aware that a letter was being circulated, which expressed concerns about BMS Advanced Practitioners reporting. This letter could be shared with the group, discussed and an agreed response reported to the SAC.
PC agreed that, from his point of view, it was appropriate to maximise the use of BMSs in cut up. However, concern was expressed that some BMSs had wasted two years, with senior BMSs being trained up and not passing the exam, returning the burden of cut ups to consultants.

It was suggested and agreed that the group approach Adrian Bateman to propose a formal review of the process.

Action: ME to prepare a proposal for the Cellular Pathology SAC that there be a formal review of the BMS Advanced Practitioner role in reporting.

WG.36/21 Date and time of next meeting

The group expressed a preference to meet virtually.

WG. 37/21 Actions arising from the Working Group on Cancer Services meeting held on 11 November 2021

Reference	Agenda item	Action(s)	Responsible	Status
WG.29/21 (a)	KPI criteria for audits/ standardised for datasets	***a) ME to review the KPI document with the inclusions of the notes discussed at the meeting and attempt to integrate the key assurance indicator document into this KPI document.***	ME	

WG.29/21 (b)	TAB specimens survey	***SB to send email trail to ME.***	SB	
WG.29/21 (c)	MDT guidance	***Draft to be shared with group once received.***	ME	
WG.29/21 (d)	Recruitment for new working group members in light of the criteria and wording for diversity and inclusion.	***ME to draft email reminder for the membership, outlining benefits and perks of the role.***	ME	
WG.30/21 (i)	Implementation of the National Genomic Test Directory for Cancer	***a) ME to update on the Task and Finish Group at next meeting.*** ***b) ME to circulate Diagnostics: Recovery and Renewal report to the Group.***	ME	
WG.30/21 (iv)	Membership and Terms of Reference	***MMF to draft policy on the process for the group to recruit lead and co-authors.***	MMF	
WG.30/21 (vii)	Revise paper – Computerised cancer histopathology reporting, data recording and downloading to cancer registries	***MMF to send the document to ME.***	MMF	
WG.32/21	Report on ICCR activity	***MMF/ME to follow up with Deborah Collins.***	MMF / ME	
WG.33/21	Progress on datasets: Breast	***MMF will put the document together and follow up with a meeting with Rahul.***	MMF	
WG.33.21	Progress on datasets: Soft tissue sarcomas	**PC to send comments to MMF** **MMF will verify before sending it to Mike.**	PC/MMF	
WG.33/21	Progress on datasets: Endocrine system (Thyroid, Parathyroid and Adult adrenal gland)	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Conjunctival melanoma	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Retinoblastoma	***MMF to follow up***	MMF	

WG.33/21	Progress on datasets: Uveal melanoma	***MMF to review final draft before open consultation***	MMF	
WG.33/21	Progress on datasets: IBD dataset	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Barrett's oesophagus	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Colorectal	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Liver	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Anal cancers	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Vulval	***(a) MMF to send version 6 to PC. (b) MMF to create a new email inbox for NICE clinical guidelines to prevent issues if staff leave***	MMF	
WG.33/21	Progress on datasets: Endometrium	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Uterine sarcoma	***MMF to follow up progress***	MMF	
WG.33/21	Progress on datasets: Carcinomas of nasopharynx and oropharynx	***MMF make sure comments to be incorporated when everything was back***	MMF	
WG.33/21	Progress on datasets: Carcinomas of the oral cavity	***MMF to follow up progress***	MMF	
WG.33/21	Progress on datasets: Carcinomas of the hypopharynx, larynx and trachea	***MMF follow up draft***	MMF	
WG.33/21	Progress on datasets: Carcinomas of the nasal cavity and paranasal sinuses	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Nodal excisions and	***MMF to follow up***	MMF	

	neck dissection specimens			
WG.33/21	Progress on datasets: Carcinomas of major salivary glands	***Encouragement was needed on it, possibly leave until the Blue Book was published.***	MMF	
WG.33/21	Progress on datasets: Mucosal Malignancies of the Pharynx	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Malignant odontogenic tumours	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Ear and temporal bone tumours	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Mucosal melanomas of the head and neck	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Lung (Lung ,TETs and mesothelioma)	***ME to follow up needed with Professor Nicholson***	ME/MMF	
WG.33/21	Progress on datasets: Peripheral neuroplastic tumours	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Renal tumours in childhood	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Germ cell tumours	***MMF to follow up***	MMF	**NEW**
WG.33/21	Progress on datasets: Lymphoma	***ME to discuss with Stefan and default to removing guideline from website.***	ME	
WG.33/21	Progress on datasets: Cutaneous lymphoma	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Penis	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Adult kidney	***MMF to follow up***	MMF	

WG.33/21	Progress on datasets: Urinary collecting system	***MMF to check when it will be published***	MMF	
WG.33/21	Progress on datasets: Prostate	***MMF to follow up***	MMF	
WG.33/21	Progress on datasets: Carcinoma of unknown primary	***MMF to follow up***	MMF	
WG.34/21	Progress on tissue pathways: Bone and soft tissue	***MMF to follow up***	MMF	
WG.34/21	Progress on tissue pathways: GI	***MMF to follow up***	MMF	
WG.34/21	Progress on tissue pathways: Head and neck	***MMF to follow up***	MMF	
WG.34/21	Progress on tissue pathways: Dermatopathology	***MMF to follow up***	MMF	
WG.34/21	Progress on tissue pathways: Gynaecological	***MMF needed to contact Raji***	MMF	
WG.35/21	Any other business i) Legal framework email	***MMF to send the email to SB for consideration***	MMF / SB	
WG.35/21	Any other business ii) Histopathology BMS reporting	***ME to prepare a proposal for the Cellular Pathology SAC that there be a formal review of the BMS Advanced Practitioner role in reporting.***	ME	

APPENDIX A

ICCR Datasets

November 2021@ Haematopoietic blue book will be reviewed by the editorial board

ICCR's development schedule follows the IARC Blue Book schedule. Once the Blue Book is nearing completion, the ICCR commences planning for the development of new datasets in the same series or updates to existing datasets. Therefore, ICCR will be starting the planning of datasets for Skin and Eye in 2022.

CNS: Blue Book in press now and should be available soon. Consequently, the ICCR dataset will be reviewed after the WHO book is published. David Louis who led the ICCR dataset last time will hand over, currently Peter Wesseling and Guido Reifenberger are considered

Proposal EANO guideline

WHO 2021 testing

State of the art testing for WHO 2021: lead Felix Sahm

- Proposed targets: 1p/19q, IDH, 7+/10-, ATRX, TERT, HD CDKN2A, TP53 (?), EGFRampl,
- H3.3, H3.1, MYB/MUYBL, MGMT
- Tumor cell % assessment
- How to report

Testing beyond WHO 2021 for targeted treatments: lead David Capper

- proposed targets: BRAF, NTRK, FGFR, NF1, TSC1/2, ALK, High TMB, MMR
- deficiency/MSI, CDK4/6, MDM2
- lists of top 15 mutated genes in glioma for relevance
- Review of clinical relevance according to the ESCAT ESMO guideline

Members:

- Sebastian Brandner
- Pieter Wesseling
- David Capper
- Felix Sahm
- Dominique Figarella Branger
- Pascale Varlet
- Pim French
- Monika Hegi
- Simone Niclou
- Michael Weller
- Wolfgang Wick
- Marc Sanson
- Matthias Preusser
- Roberta Rura
- Ghazaleh Tabatabai
- Emilie Le Rhun
- Felice Giangaspero
- Leonielle Schweizer
- Martin van den Bent