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

Meeting of the SWAG Network Breast Cancer Clinical Advisory Group (CAG, formerly SSG)

09:30–13:30, Friday 20th September 2019

Penny Brohn UK, Chapel Pill Lane, Pill, Bristol, BS20 0HH

This meeting was sponsored by Amgen and Genomic Health

Chair: Dr Mark Beresford (MB)

NOTES **ACTIONS**

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the South West Clinical Network website here.

In response to the workload pressures on CAG members, the meeting schedule will be changed to convene once a year face to face for an all-day conference with more educational content. The second meeting will be held virtually at the 6 month point to discuss any business issues that CAG need to address in the interim.

2. Review of last meeting's notes and actions

As there were no amendments or comments following distribution of the notes from the meeting on Friday 1st March 2019, the notes were accepted.

Actions:

Network audit: production of a protocol to audit the management of axilla:
To be reallocated to another Consultant Surgeon after a guideline meeting next week.

Recruitment to the POSNOC trial has been problematic in RUH Bath, with patients preferring to choose treatment options rather than participate in the randomised trial.

The recruitment process in Bristol will be shared.

Commissioning of symmetrising surgery – response from Somerset CCG: The finance policy has been agreed by Somerset CCG. Taunton and Yeovil have been given the green light to start operating. Surgical teams have been asked to submit surgical plans and to stagger the workload to avoid cancellations over the winter period. Yeovil have submitted a plan to operate on 15 patients to date. There is no backlog in Taunton; some patients independently paid for the surgery and have been advised to claim a refund from the CCG.

3. Service development

3.1 South West Genomic Laboratory Hub (GLH) **ACTIONS**

Please see the presentation uploaded on to the SWCN website

Presented by Laura Yarram-Smith (L Y-S) on behalf of GLH Cancer Lead Daniel Nelmes

In December 2018, the UK reached its goal of sequencing 100,000 genomes. Over 3,550 samples, of which 2,643 were for rare diseases, were collected by the West of England Genomics Medical Centre (GMC, which consisted of a virtual body of champions who consented patients and coordinated the necessary pathways in collaboration with the clinical teams) across all the provider Trusts.

Results are now being returned for analysis en masse, resulting in the management of a significant initial workload. Transition from a project to a standard NHS service, with continued involvement from the GMC team, is now underway by reducing the number of laboratories from 25 to a network of 7 Genomic Laboratory Hubs, all processing a core set of samples according to the same standards. North Bristol Trust was successful in the bidding process to become one of the GLHs in partnership with Royal Devon and Exeter Trust. Each hub has been given the responsibility for processing a number of additional specialist tests, which are divided so it is clear who is doing what for each indication / disease. The Director of the laboratory is Genetic Scientist Rachel Butler (RB).

National genomic test directories for rare diseases and cancer have been published here to give equity of access across the country. These define the genetic and genomic tests that will be made available via NHS England at some point in the near future (potentially April 2020); directories will be reviewed by a panel of experts on an annual basis. Three somatic indications for genomic testing in breast cancer are included. BRCA 1 and 2 testing is available in the rare disease directory.

Training in consent will be provided closer to the time.

CAG are to contact the genomics team if there are additional tests that would be useful to include in the directories; there is no funding for tests that are not included.

Future developments include detection of circulating tumour DNA. The PlasmaMATCH trial is investigating how this can inform treatment options for patients with recurrent or secondary breast cancer.

RET gene rearrangements are recommended as a possible additional test. RB is involved in a related study that might further inform this request.

4. Network issues

4.1 Multi-Disciplinary Team Meetings: Local Reforms

ACTIONS

Please see the presentation uploaded on to the SWCN website here.

Presented by Nicola Lawrence and Rachel Ainsworth

The length of MDT discussions in RUH Bath had been recorded as part of the recent National MDT Streamlining Pilot. The results showed that a minimal amount of time was spent on numerous patient discussions (on average 20-60 seconds). Initially, there was a general consensus to continue discussion of every patient, due to the occasional unexpected need for further discussion. However, after further consideration of the workload pressure associated with the MDT meeting, a process for removal of simple cases, when all information is available, is being piloted. This has involved production of an electronic proforma with drop-down data fields to triage patients into certain categories. This enables the oncologists to attend for a specific slot rather than the whole meeting. The process involves approximately 4 hours plus preparation time from a senior member of the MDT; further details are documented within the presentation. The preparation details are cut and pasted into the Somerset Cancer Register, which created the MDT list. Risks will be mitigated by continuing to review the list within the meeting.

Permission will be sought to share the electronic proforma with other centres.

RUH Team

The process, which so far has improved efficiency with the meeting now running on time, will continually be reviewed to ensure that it is safe.

It was acknowledged that centres that still have paper notes would find this process more laborious.

The NBT Breast MDT meeting regularly discussed 100 plus patients every Thursday between 08:30 and 12:30. This was far too long for attendees to concentrate, so it has been decided to split the meeting and initially discuss diagnostic results on Tuesday with one surgeon, radiologist and oncologist, and continue to hold the main meeting on Thursday. This should decrease fatigue, improve patient pathways, with diagnostic results within 7 days, improve the quality of patient discussions, and be a more efficient use of consultant time.

Systems of care for other relevant cases that could be triaged to the Tuesday meeting are in the process of being ratified. Any cases that don't fit the tight criteria will be listed on the main MDT meeting. The process will commence at the end of November 2019. The challenge is now organising the triaging process; the team was fortunate to have a highly competent MDT Coordinator solely responsible for the Breast MDT.

A time for complex case reviews of patients with metastatic disease needs to be arranged.

5. Patient experience

5.1 National Cancer Patient Experience Survey 2018 **ACTIONS**

Please see the presentation uploaded on to the SWCN website here.

Presented by Helen Dunderdale (HD) on behalf of Belinda Ockrim (BO)

A detailed analysis has yet to be completed as results were published at the end of August. Patient responses from centres ranged from 46 in Weston to 253 in Gloucestershire. Results, highlighted in green if higher than the national average and highlighted in red if lower, were generally good across the board.

There may be a need to look at the information given early on in the pathway, but this could be resolved by the increased roll out of Holistic Needs Assessments and earlier 'first steps' Health and Wellbeing events, which should be reflected in the next survey results.

The question 'was understandable information given about whether chemotherapy / radiotherapy was working' is considered flawed, and it would be helpful if the survey was redesigned, although it was possible to pick up certain themes and issues.

The most useful information is found in the free text comments which each centre will review to identify actions for improvements.

6. Living With and Beyond Cancer

6.1 LWBC Activity

Please see the presentation uploaded on to the SWCN website here.

Presented by Ed Nicolle (EN) on behalf of Evaluation and Commissioning Manager, Louise Worswick

As LWBC has been a centrally funded Cancer Transformation Project, LWBC activity (also called Personalised Care and Support for People with Cancer) is being evaluated to provide evidence of the cost benefit. Information on two evaluation time points is available to date, the first being the baseline dataset for July to September 2018; and the second being the interim results for January to March 2019.

Baseline data on completion of Holistic Needs Assessments across Trusts showed some variation. This is thought to be due to reporting issues, with several Trusts having problems with recording and extracting the activity from hospital information systems. RUH Bath has a tariff (negotiated 3 years ago by LWBC Clinical Lead Dorothy Goddard) that is reliant on the activity being reported, and a lot of work has been undertaken to ensure that this is happening.

Risk stratified follow up pathways for breast cancer patients have been implemented in all Trusts.

Cancer Support Workers are now completing the vast majority of HNAs.

Health and Wellbeing events are being held before and after treatment in response to patient feedback, although the format varies across Trusts, making it difficult to evaluate.
Evidence of the cost benefit is crucial to influence commissioners to continue funding the service after the central funding ends in April 2020. It would be particularly beneficial

ACTIONS

if it could be shown that this level of support reduces GP appointments as well as hospital outpatient or acute appointments; the agreed RUH model has been shared with the other CCGs.

HNAs are expected to be completed within 31 days of diagnosis and six weeks after treatment. In RUH, the team have found a second HNA is more relevant for patients post Cycle 2 of chemotherapy.

If CAG members are aware of LWBC activity that is currently not included in the evaluation, please contact Louise Worswick: louise.worswick1@nhs.net. The next step will be a final evaluation meeting in November 2019.

CAG members

6.2 Outputs from Holistic Needs Assessments

Presented by the CNS Team

Provision of Cancer Support Workers has resulted in patient referrals for counselling services, rehabilitation and financial support earlier on in the patient pathway and, subsequently, copious positive patient feedback.

Exercise programmes and health education are being provided in both hospital and community settings, which can be accessed at any time in the patient pathway.

7. Quality Indicators, Audits and Data Collection

7.1 Cancer Alliance Data, Evidence and Analysis Service (CADEAS) Early Diagnosis Data

Please see the presentation uploaded on to the SWCN website here.

Presented by Mark Beresford (MB)

Cancer Alliance Clinical Lead Amelia Randle requested that the CAG analyse the CADEAS early diagnosis (ED) data for breast cancer, which shows a lower early diagnosis rate for Stage I and II cancer diagnoses in the SWAG region for 2017 in comparison with the Cancer Alliance that has the highest ED rate.

Further breakdown of the data showed that the ED rate from 2013-2016 was between 85-87% in line with expected rates, and the drop in 2017 was mostly attributed to the Bath region.

Breast cancer screening rates were higher than average (72.6% in comparison with England uptake of 70.5%), and Cancer Waiting Times were consistently above the national average over this time period.

Data completion was not thought to be an issue, given that incomplete data sent from the Trust was completed retrospectively by the National Cancer Registration Service. This was available on the Cancer Stats website and, following review of a graph on the staging data for 2017 from this website, it was agreed that the data quality should be further investigated; data from Weston showed no Stage I and II diagnoses during this period, which was definitely incorrect. The CADEAS data was also not thought to correlate with the data from the National Audit of Breast Cancer in Older Patients.

HD

ACTIONS

It was noted that when entering TNM staging data on the Somerset Cancer Register, completing the 'M' field with an X would confuse the system, and should instead be completed with zero (0).

Information could be pulled from sources used by Trust management teams to assist with the investigation.

7.2 SWAG Breast Cancer Staging Investigations

Presented by Tom Wells (TW)

Following results of an audit on staging investigations presented in 2018, it was concluded that postoperative staging was not recommended for the majority of Stage I and II disease, and the evidence on the imaging modalities for assessing Stage III disease (a significant number of which have metastatic disease) was considered out of date.

A network audit was proposed to assess the pick-up rate of metastatic disease using current imaging modalities, and the subsequent management benefits, to define who should have what investigation and at which point in the pathway.

The current provision of staging investigations in the adjuvant and neoadjuvant setting has been established via a survey sent prior to the meeting.

Current practice in Weston is to perform staging investigations on Stage III and IV cancers.

Stage defined:	T1N2 disease, <5cm tumour, four or more nodes
	T3 + N1-2, >5 cm tumour, any lymph node invasion
	T4 inflammatory disease/invading into local structures

PET-CT is used for inflammatory cancers and CT Chest Abdomen Pelvis (CT CAP) for all other cases.

Practice is very similar across the region, with slight variation in some centres. For example, staging investigations for patients with tumours >5cm when there was uncertainty about nodal involvement.

Gloucestershire, UH Bristol and Taunton perform MRI in line with NICE guidelines, and Yeovil send selective cases for isotopic bone scans.

CT CAP was not considered sufficient for the detection of bone metastases. PET-CT may be the preferred imaging modality for inflammatory disease.

Staging investigations can also be required for Stage IIB triple negative HER2 positive plus 1 node cases, and young patients.

Network guidelines will be drafted by TW and circulated for comments.

TW

8. Research

8.1 Clinical Trials Update **ACTIONS**

Please see the presentation uploaded on to the SWCN website here.

Presented by Mark Beresford on behalf of David Rea

The National Institute for Health Research (NIHR) has revised the high level objectives from 2019/20 as detailed in the presentation.

There is an 80% patient recruitment target for both commercial and non-commercial trials.

Set up targets are now 80 days for commercial studies and 62 days for non-commercial.

Set up of trials often seemed to take much longer than anticipated. It was hoped that the immunotherapy trial A-BRAVE could open in the region in June 2019, when a number of relevant patients had been identified, but it has been delayed until this week and the patients are now no longer eligible. It is uncertain when the next eligible patient will present, and likely that the recruitment target will be missed.

The former 30 objectives have now been replaced with 5 harmonised objectives. New Chief and Principal Investigators will be sought for areas of research that are currently under-represented.

Specific areas of focus for the NIHR are surgical trials, which are inherently difficult to recruit to, radiotherapy, rare cancers and TYA trials.

There is a dearth of new radiotherapy trials. PRIME II, which looks at avoiding radiotherapy for low risk tumours, is difficult to recruit to as the majority of patients want the radiotherapy. The surgical team and breast care nurses are doing their best to prime patients that they may not need radiotherapy and relevant patients are being identified in the MDTs.

Qualitative recruitment studies are underway, as discussed in the previous meeting, which include the topic of unconscious bias that can be picked up from observing discussion of clinical trials with patients that can then be reported back to clinical teams.

Recruitment figures (sourced from EDGE), open trials and trials in set up are documented within the presentation, which also includes a list of useful links for people to check for trial availability. CAG members are invited to contact the research team for further information on trials that they might wish to open.

The potential to provide recruitment training by a trials team at a future meeting will be investigated.

HD

Date of next meeting: Friday 13th March 2020.

-END-