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 13th March 2020

Bailbrook House, Eveleigh Ave, London Rd W, Bath BA1 7JD

Chair: Professor Mark Beresford (MB)

NOTES **ACTIONS**

(To be agreed at the next CAG Meeting)

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 virtual meeting will be held 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 20th September 2019, the notes were accepted.

3. Clinical Guidelines

3.1 San Antonio Breast Cancer Symposium 2019

Please see the presentation uploaded on to the SWCN website

Presented by Prof Mark Beresford

An update on the latest clinical guidance was provided on the following subjects:

- Hormone Receptor Positive Disease
    - The Early Breast Cancer Trialists' Collaborative Group - distant recurrence
    - Extended adjuvant endocrine: NSABP B-42 Trial update
    - PEARL study – metastatic ER +ve.
- HER2 positive
    - Margetuximab
    - Trastuzumab deruxtecan.

ACTIONS

- Chemotherapy
    - Oral Paclitaxel.

- Radiotherapy
    - Partial breast radiotherapy.

- Surgery
    - Image-guided biopsies post-neoadjuvant chemo.

- Genomic profiling
    - PlasmaMatch - Multicentre trial of ctDNA testing in patients with advanced disease.

Details are available in the presentation.

3.2 Breast Cancer Staging Protocol

Please see the presentation uploaded on to the SWCN website

Presented by Dr Tom Wells

A review of evidence was undertaken to establish if it would be appropriate to reduce post-operative staging investigations for cases of Stage I and II breast cancer, and to align the staging investigations undertaken for all other stage disease. Results have been documented in a SWAG Breast Cancer CAG Staging Protocol and circulated for ratification by the group.

AGREED

4. Patient experience

4.1 CNS Perspective on Clinic Consultations

It is essential for Breast Care Nurses (BCNs) to attend all appointments with new patients to provide support at the time that their diagnosis and treatment plan is discussed with the Consultant; the BCN is the advocate for those patients that attend their appointments without a companion.

BCN attendance at Consultant appointments and the time spent with the patient and their family afterwards does not currently generate a tariff, and should be properly recognised and recompensed.

There are currently not enough numbers of rooms for private patient discussions in the Bristol Haematology Oncology Centre.

Clinic lists are reviewed prior to each Consultant clinic to identify which patients the BCNs need to see, but it can be difficult to see all those identified as they are often in clinic at the same time.

5. Multi-disciplinary Team Reforms **ACTIONS**

5.1 MDT-MODE Assessment Results

Please see the presentation uploaded on to the SWCN website

Presented by Helen Dunderdale

Background:

- Multidisciplinary team (MDT) working is seen as the 'gold standard' in many countries
- Care of cancer patients has become more complex due to the increasing numbers of diagnostic tests, treatments, and increased patient empowerment in decision-making
- When MDTs do not work together effectively care can be sub-optimal; recommendations can be clinically inappropriate, or not acceptable to patients, resulting in delays to treatment, distress for patients and frustration for healthcare professionals
- Effective MDT decision-making requires consideration of comprehensive patient-centred information at the point of decision-making.

Method:

The Breast Cancer MDT in North Bristol Trust was assessed on three occasions by a trained assessor using the validated assessment tool MDT-Mode, which measures the quality of information and contributions for every individual patient discussion.

Preliminary Results:

- 299 patients were discussed over 3 meetings - 95, 103 and 101, respectively
- 2min average discussion time per patient, ranging from 20 seconds to 7min
- 37 cases deferred to another meeting
- 15min meeting break occurred in the observed MDT after discussion of 48 cases in the first meeting, and 56 cases in the next two meetings.

Discussion:

As discussed in the first meeting of SWAG Cancer Clinical Leads, the prolonged length of meetings has been proven to reduce quality of decision making, particularly after the first hour, or discussion of 20 patients. The addition of a 10 minute break at this point has been shown to balance the quality of decision making and reduce the length of the overall meeting.

The cognitive fatigue caused by the length of the NBT MDT has already been discussed, and it has been agreed to split the meeting over 2 separate occasions.

Best practice to share with other MDTs:

ACTIONS

- **Meeting room** is configured in a U-shape which allows participants to see and hear each other clearly
- **Case discussions** are ordered according to the patient pathway, which allows oncologists to attend a specific slot in the meeting
- **Role of Chair, Pathologist and Radiologist** is rotated half way through the meeting
- **Surgeon** who knows the patient introduces the case history
- **Research nurse** facilitates discussion of relevant research trials
- **MDT outcome** is relayed directly to the MDT Coordinator, typed immediately into the Somerset Cancer Register, and checked for accuracy by the relevant attendees

For consideration:

- Are some professional groups under represented when they shouldn't be? Could Chairing help with this?
- Are certain types of information under represented when it would be useful?
- Could pathology provide a cut-off date for listing cases to report results from surgical samples?
- Could some of the benign cases be removed if planning time is scheduled?
- Could attendance be reduced further for particular sections of the meeting?

Once the new format of the MDT meeting has become embedded, the meeting will be reassessed and compared with the previous MDT-Mode data. **H Dunderdale**

6. Research

6.1 SWAG Clinical Trial Update

Please see the presentation uploaded on to the SWCN website

Presented by 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. 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; for example, expressions of interest from radiology / radiographers would be welcome.

Specific areas of focus for the NIHR are surgical trials, which are inherently difficult to recruit to, radiotherapy, rare cancers and Teenage and Young Adult (TYA) trials. A TYA Research Nurse has recently been appointed; the role will be based in the Bristol Haematology Oncology Centre, but will have a network-wide remit.

Recruitment figures (which are shown to be performing well as a region), open trials, trials in set up, and open to new sites, are documented within the spreadsheet and presentation, which also includes a list of useful links for people to check for trial availability; these will be circulated and uploaded on to the SWCN website. **ACTIONS** **H Dunderdale**

6.2 OPTIMA

Please see the presentation uploaded on to the SWCN website

Presented by Rob Stein

Hypothesis

- Multi-parameter assays predict the sensitivity of tumours to chemotherapy.

Objectives

1. To establish a method of selecting patients with hormone sensitive primary breast cancer who are likely to benefit or not benefit from post-operative chemotherapy.
2. To establish the cost-effectiveness of alternative test-guided treatment strategies compared to standard practice.

Please see the presentation for further information, including details of SWAG recruitment on slide 25.

Recruitment can be optimised by engaging all colleagues to view contributing to OPTIMA as a team activity, and ensuring that patients receive the consistent message that not all patients benefit from chemotherapy, and that hormone therapy may be the preferable treatment option.

The biggest barrier to recruitment is if eligible patients are told that they are going to have chemotherapy before OPTIMA is discussed.

Guidance has been produced to facilitate the consent process, and resources are available on the website here. For further trial support, please contact Senior Research Associate Dr Carmel Conefrey: carmel.Conefrey@bristol.ac.uk.

As OPTIMA avoids chemotherapy in approximately one third of patients, this would be particularly helpful in light of the impending COVID-19 pandemic, with patients on chemotherapy being particularly vulnerable to severe COVID-19.

CAG Patient Representative Jo Chambers was asked for feedback on the patient experience when being approached to consider consenting to a research trial (response expanded upon post meeting):

Information is vital to ensure that any fears on possible negative outcomes are overcome. Getting a cancer diagnosis in the first place is scary; if someone is asked to consent to a trial that may risk under-treating it for example, particularly when there is a huge amount of information out there now about what the 'normal' course of treatment

would be, is a big decision to make. It is important to understand the benefits, what the risks are and how they will be mitigated/reduced, and give reassurance that there is evidence to show a reduction in treatment for example could be the best course of action. Understanding the background as to why the trial is happening may be useful. However, the amount of information that is useful will vary person to person.

ACTIONS

Timing of passing on that information is also important. It is hard to take in the initial diagnosis at that first appointment, let alone much more. Sew the seed about a trial at that point but it may need a further appointment to go through the trial details properly.

Using a range of methods of communication is helpful, for example, verbal, leaflet, online resources. Having something to read after that initial appointment to allow you to take it in would help. And the first thing that most people (or their families) will now do is use google, so signposting straight away to useful sources of online information on the trial would prevent any inaccurate information being read.

Give patients time to make a decision and also ask questions. As a patient, it can feel like all control of your life is taken away from you the day you get the diagnosis and you consent to what can be a long period of intensive treatment. So let them feel in control of that decision and not feel rushed. Even if there is a tight deadline, where possible allow the patient to feel in control even if it is just giving them 24hrs to think about it. If they feel it was their decision rather than being pushed into it they would be more likely to go through with it.

Consistency of messaging about the trial and its benefits from the whole team that the patient comes into contact with right from the start.

Speak to patients undergoing the trials to see what they would say to prospective new trial subjects. Sometimes a patient explaining to a patient can be more effective, so potentially passing on information from current or former trial participants may help new patients make a decision.

6.3 POSNOC and ATNEC

Please see the presentation uploaded on to the SWCN website

Presented by Amit Goyal

POsitive Sentinel NOde: adjuvant therapy alone versus adjuvant therapy plus Clearance or axillary radiotherapy (POSNOC) is a randomised controlled trial of axillary treatment in women with early stage breast cancer who have metastases in one or two sentinel nodes.

It is the first and largest UK led international breast cancer surgical trial. The trial design, inclusion and exclusion criteria are documented in the presentation.

The main reason that eligible patients decline to enrol is because they want axillary treatment; a percentage also decline because they don't want axillary treatment, and many reasons are unknown.

Recruitment has increased exponentially since 2014, with Southmead Hospital being the third highest recruiter at present.

ACTIONS

Axillary management in **T**1-3N1M0 breast cancer patients with needle biopsy proven nodal metastases at presentation after **ne**oadjuvant **c**hemotherapy (ATNEC), will be the largest and first UK led international neoadjuvant breast cancer surgery trial.

Start date: 1st March 2020

Trial design, inclusion and exclusion criteria are documented in the presentation. SWAG centres are encouraged to open the trial.

7. Any Other Business / Management of Services during the COVID-19 Pandemic **CAG members to consider**

Treatment options may need to be adjusted in response to the risks associated with COVID-19.

Services may need to be split to have clean areas for oncological treatments.

To aid clinical decision making on the delivery of chemotherapy during the pandemic, CAG recommend that Onco-type DX or Prosigna is made available to select patients with 1-3 positive nodes, in addition to NICE guidance for intermediate risk ER+, HER2-, node negative patients, who would normally be considered fit enough to be offered chemotherapy. Funding will be sought from the Cancer Alliance. **AGREED**

Date of next meeting: To be confirmed and held via WebEx or MS Teams

-END-