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

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

11:00–12:00, Friday 18th March 2022 via MS teams

Chair: Professor Mark Beresford (MB)

NOTES (To be agreed at the next CAG Meeting)	**ACTIONS**
1. Welcome and apologies	
Please see the separate list of attendees and apologies uploaded on to the SWAG website here.	
2. Review of Previous Meeting Report	
As there were no amendments or comments following distribution of the notes from the meeting on Friday 13th March 2020, the notes were accepted.	
At the last meeting, CAG recommended extended provision of Oncotype DX testing during the COVID-19 pandemic for the purpose of potentially avoiding chemotherapy in post-menopausal women with 1-3 positive nodes and a low Oncotype score, as there is strong evidence that this is appropriate. At present, the test was only funded for node negative patients. The Cancer Alliance agreed to provide the additional funding on a temporary basis.	
A table had been produced with the estimated number of patients who might need the test per month. Although the origin of the data was unclear, it looked like an appropriate number of patients.	
Recruitment to the OPTIMA trial was encouraged as this will provide further evidence that should influence NICE to routinely fund the test for this node positive group, hopefully this will be agreed in the next few months.	
In the interim, CAG recommend that the additional temporary funding is continued, although it is understood that other temporary funding streams to support systems during COVID have recently been stopped.	**CAG Recommendation**
So far, no one has invoiced the CA for the extra tests although they have been requested. H Dunderdale has been trying to make appropriate contacts to find out how many extra tests have been requested and to see who can raise the invoices to ensure Trusts are properly recompensed.	
Action: The request for information on the extra Oncotype DX tests and who should raise an invoice will be sent to Cancer Manager T Agnew, who sits on the Pathology Work Group Board.	**H Dunderdale**
Lists of the tests are also routinely available from other Trusts.	
Action: H Dunderdale will confirm with the CA if the funding will continue.	**H Dunderdale**

3. Research

3.1 Clinical Trials Update

Please see the presentation uploaded on to the SWAG website

Presented by C Matthews

Research Delivery Manager for the West of England CRN, C Matthews, manages the cancer portfolio, and works closely with Clinical Specialty Lead for Cancer, H Winter.

The geography of West of England CRN differs from the SWAG region; data from SFT and YDH will be sourced from the Peninsula CRN for future meetings.

Contact details can be found in the presentation.

Two years of pre-pandemic research activity, compared with data from April 2021-22, shows that there were obviously far fewer patients recruited to research, but still nearly 30,000, which is an impressive number considering current working conditions.

When comparing regional with national data, research activity can be seen to be recovering well in 2021/22 following the initial drop when many trials were paused.

The spike of increased recruitment in the West of England is largely caused by two high recruiting trials; PROSPECTS in NBT, and BRAID in GRH.

PROSPECTS, which looks at different screening methods, is hoping to recruit 100,000 patients. The trial opened in 2018 and is due to close in July 2022. NBT is the 4th highest recruiter in the UK.

The trials that have opened in the last financial year are listed in the presentation, as are the trials currently in set-up. The full list of open trials is in a spreadsheet which is available on request.

Action: CAG members to contact C Matthews who can share complete list of open trials. **CAG**

Cross-referrals between centres could be improved by providing specific information on the trials available in each centre.

Gynae Sub-Specialty Research Lead, R Bowen, routinely shares a summary of the relevant trials open in each centre. This has been successful in prompting cross-referrals over several years.

RUH have just opened ZEST and have recruited 3 patients to date, all of whom have been outside referrals. This is for women who have completed treatment for a triple negative or BRCA related breast cancer, as long as it is HER2 negative, who then undergo testing for circulating tumour DNA. If CT-DNA is detected and the patient has no metastatic disease, they can be randomised to receive either neratinib or placebo. Patients seem keen to travel for the opportunity to participate.

A summary of the trials open in each centre will be produced.

Action: M Beresford and C Matthews will identify a representative in each centre to compile the open trials list and put this on the website so it can be viewed in clinic. **M Beresford, C Matthews**

4. Clinical Guidelines

4.1 SACT Protocol Update / Clinical Guidelines

Presented by H Dunderdale

An update on the current status of SACT protocols was given on behalf of network pharmacist, K Gregory, who was unable to attend the meeting today.

There are currently 32 protocols published on the SWAG website; 19 need to be reviewed and updated. This should not be too onerous, as many may just require confirmation that nothing has changed. Any volunteers to help with the process are to contact K Gregory: kate.gregory@uhbw.nhs.uk

Three protocols are currently in development:

- EC-Carbo/Weekly paclitaxel has been drafted
- Dose dense EC Carbo/Weekly paclitaxel has been drafted
- MMM.

Consensus was sought from CAG regarding dosing of EC for neoadjuvant/adjuvant protocols instead of FEC. BHOC have currently dropped using the 5FU. RUH is also using the same altered regimen.

Action: To update Herceptin protocols with specialist input from cardiology colleagues. — **T Strawson-Smith / K Gregory**

Consensus is sought to reduce the SWAG Breast Cancer Clinical Guidelines, required to comply with Quality Surveillance, from an extensively detailed 90-page document, to a 5 page summary containing links to national guidance. — **AGREED**

Action: To add a link to the Royal College of Radiotherapy Breast Cancer Guidelines. — **H Dunderdale**

CAG members are to send any other links that they would want to include in the document.

NHS England Regional team (Region) has asked if there had been any opportunities to streamline the breast pain pathway. In 2021, Region shared the Brighton and Sussex optimised pathway model. NBT have implemented several changes, with a new straight to test pathway and specialist MDT.

Action: T Agnew will write a formal response to NHS E Region on the changes that have been implemented. — **T Agnew**

5. Clinical Opinion on Network Issues

5.1 MDT Meeting Reforms

Presented by N Lawrence

The Association of Breast Surgeons (ABS) have produced a tool pack on how to streamline MDT meetings due to the need to manage the current workload. Many outcomes can be protocolised. In RUH, it was not felt to be feasible to set up a separate MDT for this purpose, and so all patients remain on the list. To make the meeting more efficient, a dedicated clinician has a 5 hour session to go through all the pathology and propose the MDT outcome, which is then pre-populated on the list prior to the meeting. This speeds up the meeting, with minimal time spent on the simplistic cases, but also allows pathology and/or radiology the opportunity to provide additional input if a case is not felt to be as straightforward as predicted.

The process has definitely improved the efficiency of the meeting and, although it is a lot of work for the dedicated clinician of the week, this alleviates the workload for the rest of the team.

ABS suggests a separate MDT with fewer people to manage the triage process but the RUH approach is felt to be more efficient.

A similar process has been implemented in YDH. The Consultant Breast Surgeon and Breast Care Nurse Specialist meet one or two days prior to the main MDTM to pre-populate outcomes for all of the benign and HER2 negative cases. These remain on the MDT list and the team are emailed to ask if additional input is required but are otherwise not discussed. The number of MDT case discussions was noted to have increased exponentially over the last few months.

All cancers are still discussed, and the next step could be to further investigate adoption of the ABS guidelines.

Lead Cancer Nurse L Wilks, who will now represent the regional LCNs at the Breast CAG, confirms that the NBT breast MDT are also reviewing protocolising cases in line with ABS guidelines.

UHBW Colorectal MDT have streamlined case discussions by circulating pathology prior to the meeting and filtering out those cases where discussion may lead to deviation from protocolised outcomes and make for quicker decisions in the room.

Pathology still needs to be discussed by the MDT where there are areas of uncertain significance, to ensure that the report has been correctly interpreted.

It is important to be mindful of the communication cues that could be lost due to the use of MS Teams rather than face to face meetings.

5.2 Management of Services during COVID

MS Teams is, in general, working well but it was recognised that some communication is compromised, and hybrid meetings may be the preferred model.

This is already the model for NBT and YDH MDTM. Surveys have been undertaken to establish how people find the different models of virtual versus hybrid. It is felt that both can work but are dependent on the individual's behaviour. Face to face teams need to ensure virtual attendees are engaged in the discussions.

It was noted that COVID funding to allow Pertuzumab and Herceptin to be given without chemotherapy, due to the perceived additional risks during COVID, has now been withdrawn. Funding to switch to Capecitabine for people on HER2 therapies has also been withdrawn.

6. Quality Indicators, Audits and Data Collection

6.1 Management of the Axilla Audit / Any Other Audits

Management of the axilla audit had been planned prior to the COVID-19 pandemic. This was still considered relevant to audit as there is variation across the country. ATNEC trial is due to open in UHBW which may change practice, so it would be useful to look at current practice before this starts.

A table was recently put together to combine the ADS and RCR guidelines on how to manage sentinel lymph nodes as an initial guide to manage these MDT discussions. Three or more positive nodes were considered more straightforward as they would be directed for further treatment with either surgery or radiotherapy.

Discussion of cases with 1-2 positive nodes are more difficult to categorise; this will continue to be unknown until results of POSNOC and ATNEC have been published. In the interim, a more protocolised regional approach could be chosen to standardise practice across the region.

Action: H Dunderdale will circulate the table to each centre with an audit proforma to establish current practice in each centre. **H Dunderdale**

There are situations where further axillary treatment may be considered but this is not currently documented in the table. The field of nodal therapy will be part of the discussion.

7. Personalised Care and Support

7.1 CNS Update

The CNS team in NBT and Weston have continued to run face-to-face clinics and Living Well and Beyond Cancer programmes throughout the pandemic. Living Well days, which is a 4-week post-op follow up, will resume in the near future.

Referral numbers have greatly increased, as have the number of patients requiring oncological treatments at BHOC plus the resulting queries, and this has had a big impact on the team.

CA funding has since been secured for an additional Band 6 nurse for 2 years. The breast team are reviewing the service across the board. It is hoped to restart the work on nurse-led histology clinics that was underway pre-pandemic.

8. Any other business / format of next meeting

CAG will aim to meet once a year face to face and will include educational content.

A second shorter virtual business meeting would be useful to review achievements and challenges. Cancer Managers rely on the governance of the Cancer Clinical Advisory Group to ratify any pathway changes, which also helps with business planning.

Date of next meeting: To be confirmed and held Face to Face / via MS Teams in September 2022

Addendum

Options following positive Sentinel Lymph Node Biopsy
if clinically node negative at baseline

	Recommend further axillary treatment (ANLD or Axilla field RT)	Unclear - discuss options	Further axilla treatment not required (if having tangential breast/chest wall RT)
Isolated tumour cells/micro mets			all
3 or more nodes	all		
1-2 nodes involved	T3 G3 ER-ve	T2 Premenopausal ENE/LVI Her 2 +ve	Post-menopausal T1 G1-2 ER+ve HER2-ve

-END-