

Meeting of the Breast Cancer Clinical Advisory Group

Tuesday 10th October 2023, 15:00-16:00 via MS Teams

REPORT

Chair: Professor Mark Beresford

NOTES

ACTIONS

1. Introductions and review of last meeting's notes and actions

Please see the list of attendees and apologies available on the SWAG website [here](#).

At the last meeting, a second update on the impact of new NICE TA approvals and the pan-alliance breast cancer group to escalate capacity issues was provided; the message has started to make its way up the various levels in NHS England and other supporting bodies who are now looking at how to manage the effects on oncology capacity, particularly for patients with metastatic disease.

There was also an excellent presentation from Patient Representative J Chambers on the patient experience and how little things make a big impact. Unfortunately, J Chambers has since passed away, but has left the group a comprehensive version of her presentation if anyone wishes to access this in the future (not for publication). She provided Breast CAG with a lot of support over the past three years and will be missed.

National Cancer Treatment Variation was also discussed and is back on the agenda today for consideration by the Surgical Team.

Improving the collaborative approach to recruiting to trials will also be revisited.

As there were no amendments requested to the previous report from Tuesday 20th September 2022, the report was accepted as finalised.

2. Service improvements

2.1 Genomic Medicine Service Alliance (GMSA) Update

Presented by Associate Director of Nursing and Midwifery Dr Tracie Miles

Since the meeting in March 2023, genomic medicine has become increasingly nuanced.

A film has been produced, which is one of six animations that are going to be available in the public domain in the near future once final permissions have been granted.

The films were co-designed; J Chambers was the lead patient voice who helped inform the content.

The films can be used within or prescribed ahead of the patient's consultation.

There is also a project which is being piloted in RUH, SFT, and RCH. This is looking at mainstreaming online counselling and consenting, which needs to be undertaken in the diagnostic workup to ensure that the genetic profile is known in time to prescribe the appropriate treatments.

A growing network of nurses, called the R208 network, is forming from Gloucestershire down to the Peninsula. They are receiving support with genomic education and training from the SW GMSA.

Breast CAG is invited to contact Tracie with any GMSA queries:

tracie.miles@nhs.net

The first 2 minute film was played to the group.

UKCGG have peer reviewed the films to ensure that they will all be fit for purpose.

Action: Links to the films will be circulated as soon as available.

**T Miles/H
Dunderdale**

Any comments on the content will be welcomed.

Discussion:

Currently, the only way that the oncologists are able to access the patient's results is to ask the patient when they arrive in clinic. Ideally, the results should be available via the Integrated Care Environment (ICE) Hospital Information System.

The GMSA team are currently looking into completing the form to include three failsafe email contacts for the return of results.

All other cytogenetic results are uploaded to ICE by the histopathology laboratory. However, this is only possible for somatic results but not germline.

Action: Breast CAG Oncologists will write to T Miles to escalate the need to improve the reporting of germline results.

**Oncologists /
H Dunderdale**

3. Patient experience

3.1 National Cancer Patient Experience Survey (NCPES 2022)

Please see the presentation uploaded on to the SWAG website

Presented by Lead Cancer Nurse (LCN) Hannah Little, representing the regional LCNs

NCPES is an annual survey; the 2022 version is the 12th iteration. It is commissioned and managed by NHS England and overseen by the National Cancer Patient Experience Survey Advisory Group.

Picker is responsible for the technical design, implementation, and survey analysis.

NCPES is used to monitor national progress on experience of cancer care, provide local information to drive quality improvements, assist commissioners and providers of cancer care and inform the work of the various charities and stakeholder groups supporting patients.

The survey is sent to NHS patients aged 16 or over with a primary diagnosis of cancer who have an inpatient or day case attendance for cancer related treatment between April-June each year. Results are received over a year later, which needs to be considered when interpreting the data.

There is a free-phone helpline available for help with translation as the survey has not been published in different languages. Feedback has been provided to Picker that this needs to be addressed.

Responses from patients treated in SWAG from outside the SWAG postcode area will be attributed to the Cancer Alliance within the postcode area.

SWAG total response rate was 58%, which is 3417 patients, only 7 of which used the translation service. Work needs to be undertaken to improve response rates from patients whose ethnicity is other than white and from areas of deprivation.

SWAG Breast Cancer Services received 808 responses, which is the highest response rate in comparison to the other cancer sites. Eight questions scored higher than the expected range, and are very good at sign posting patients to receive financial assistance.

A few questions were 5% below the national average including Questions 31, 35, 37, which all related to the pressures on general surgical wards and are outside the control of the CAG.

Question 55, 'patient was given enough information about the possibility and signs of cancer coming back or spreading', also fell slightly below the national average.

Question 58, 'Cancer research opportunities were discussed' was also below the national average, with 33% of patients saying that research was discussed in comparison to 40% across SWAG and 43.1% across the nation.

Breast CAG are asked to consider how to improve discussion of research. This was felt to be due to the portfolio of trials currently available, which are targeted to specific and small patient groups. Numbers could be improved if there was access to a large, easy recruiting Phase 4 questionnaire trial.

It was recognised that there is a limited amount of actions that can be drawn out of the NCPES data as it is a year old.

The majority of complaints seem to arise from emergency admissions and feeling ignored on a ward. This pathway requires improvement to increase patient awareness that work is underway on their behalf during the times when they are not physically being visited by a member of the ward team.

4. Clinical Guidelines

4.1 NICE TA's update

Presented by Consultant Clinical Oncologist Mark Beresford

No further NICE TA's have been approved since the March 2023 meeting.

ENHERTU is going through the NICE approvals process at present. This is for HER2 node positive patients. The initial review suggests that it won't be eligible for funding; an update will be provided at the next meeting.

5. Clinical opinion on network issues

5.1 National Cancer Audit of Treatment Variations

The request to look at treatment variation, sourced from the 2014-19 audit on breast cancer treatment in older patients, asked that 'breast cancer surgical teams should examine their reoperation rates after breast conservation surgery to identify areas where reoperation rates can be reduced, whilst supporting safe breast conservation'.

Data showed RUH as an outlier in re-excision rates. National data is around 15-20% and RUH were shown to have a 30% rate. On examining local data, the actual re-excision rate is lower than average, being 10%, showing that there is an error in the data submitted to the national audit.

A recent webinar looking at re-excisions compared the data from the older patients' audit with data gathered for Getting it Right First Time (GIRFT) and a National Margins audit. Most centres found that their data was different from that recorded nationally. One of the reasons is because vacuum incision biopsies, which are increasingly being performed, can sometimes be coded as a first procedure, resulting in the first excision being coded as a second procedure.

It is however practice to code vacuum excisions as a first excision to ensure that the appropriate tariff is generated.

Action: H Dunderdale will send this feedback and the local data to the Cancer Alliance team. H Dunderdale

Date of next meeting: Friday 15th March 2024, Bailbrook House, Eveleigh Ave, London Rd W, Bath BA1 7JD

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