Meeting of the SWAG Network Breast SSG

09:30–13:30, Friday, 30th June 2017 at Penny Brohn Cancer Care, Pill, BS20 0HH

This meeting was sponsored by ASTRAZENECA, KYOWA KIRIN, PFIZER PHARMACEUTICALS and ROCHE PRODUCTS LIMITED,

Chair: Dr Mark Beresford (MB)

NOTES
(To be agreed at the next SSG Meeting)

1. Review of last meeting notes and actions progress

As there were no amendments or comments following distribution of the notes from the meeting on 27th January 2017, the notes were accepted.

Actions:

Production of network guidelines for extended endocrine therapy: A letter will be circulated which has been produced to provide General Practitioners (GPs) with advice on extending endocrine therapy from 5 to 10 years, if tolerated. This was for management of the historical patient population that may not be seen again in clinic at this point; current patients are made aware of the new guidelines.

Living With and Beyond Cancer: Best practice templates for chemotherapy, radiotherapy, surgery, and metastatic disease are available on the SWCN website here.

2. Service development

2.1 West of England Genomic Medicine Centre (GMC)

Presented by Mark Beresford

The West of England GMC started recruiting patients with breast cancer to the 100,000 Genomes Project in June 2016, initially opening in North Bristol Trust, and more recently in Gloucestershire and Bath. It has become available for other cancer sites, including colorectal, gynae, brain and haematological malignancies to date; the live pathways and recruitment figures are documented within the presentation. Recruitment across the UK was lower than initially projected. An audit of the patients seen in NBT between 29th September 2016 and 16th March 2017 showed that the majority of patients were not eligible to enrol, and a percentage of those who were eligible declined to consent due to the timing and complexity of the consent process. This would resolve when full genome sampling was standard care and did not require a separate consent process. There were also cost implications; the Trusts were only recompensed for successful samples, and the money provided did not cover the cost of the processes involved. The eligibility criteria has recently been amended to include patients who have had neoadjuvant therapy or recurrent disease.
2.2 SABR

Please see the presentation uploaded on to the SWCN website

Presented by Charles Comins (CC)

Since the service commenced in February 2014, 330 referrals have been received and 250 patients treated, 30 of which were patients with oligometastatic disease. The majority of inoperable patients consent to the treatment, and some patients choose SABR as an alternative to surgery. Referrals have been received from across the South West region. Centres in Plymouth and Exeter will have the capacity to provide the service in the next few months.

Details of a snapshot audit are documented within the presentation. This was limited due to missing documentation of toxicity details and difficulty in interpreting whether radiological changes were caused by radiotherapy or disease progression. Data collection will be improved prior to the next audit.

MDT members are to consider the randomised trials SARON, CORE and HALT for patients with oligometastatic disease, and in particular CORE for breast cancer patients; the trial schema, aims and objectives are documented within the presentation.

Patients receiving chemotherapy at the Bristol Haematology Oncology Centre (BHOC) usually have follow up appointments every three months in Bristol, but the trial sponsor will be contacted to see if local follow up is possible.

It is hoped that SABR can be offered as a treatment option for spinal metastases from next year.

2.3 Radiation Injury Rehabilitation Service

Presented by Charlie Ewer-Smith (CE-W)

Patients from across the UK can be referred to the Breast Radiation Therapy Rehabilitation Service (funded by NHS England) in the Royal National Hospital for Rheumatic Diseases Bath, where treatments are given to assist recovery from complex conditions such as chronic pain, loss of function, and emotional difficulties, caused by the long term effects of radiation treatment. The service has demonstrated clinically significant improvements in patient performance outcomes. Macmillan funded a pilot project to treat patients with long term effects post-surgical/other treatments which again had positive outcomes for historic patients. It is hoped that further funding can be sourced for this to continue long term. Evidence of relevant patient numbers from treatment centres and community services would be beneficial to capture; there was thought to be many people in this group with unmet needs. This will be discussed further with the Living With and Beyond Cancer working group.

Referrals can be made via phone or email by any member of the clinical team or individuals can refer themselves:

Tel: 01225 473481 to refer
3. Network Issues

3.1 Cancer Research UK MDT Recommendations

Please see the presentation uploaded on to the SWCN website

Presented by Mark Beresford

CRUK conducted a research study, which is available via this link, to see how multi-disciplinary team meetings can be made more efficient. Since their formation in 1995, demands on cancer services have increased exponentially. The findings and recommendations from the study are documented within the presentation, and are summarised below.

The report recognised the importance of ensuring that the additional benefits associated with MDTs were not lost with the proposed changes.

Recommendation 1, to use standardised proformas, was the current practice, but documentation of social status, patient preferences and performance status could be improved, as could the documentation for cross referrals. The systems available for cross referral varied; an example of best practice was the process available on the Bristol Neuro-oncology Group (BNOG) section on the North Bristol Trust website. The process for referring to plastic surgery needed to be clarified.

Recommendation 2, for the completion of proforma to be mandatory and include all relevant clinical details would assist with the correct completion of COSD and staging data. Completion of the HER2 field on the Somerset Cancer Register needed to be monitored, as this was sometime missed due to the result coming back at a later date.

Recommendation 3, real time, projected electronic completion MDT outcome data that was checked for accuracy could be addressed by giving MDT Coordinators the permission to clarify the conclusions of each discussion before moving to the next case; the majority of MDTs already follow this practice.

Recommendation 4 was to optimise the infrastructure and video-conferencing facilities, in a style that ensure participation from all group members. There was variation in the quality of video-conferencing facilities across the region that was in the process of being addressed.

Recommendation 5, to have a named, trained, supported Chair, with ring fenced time in their job plan to prepare, was essential to ensure a smooth running MDT; visiting neighbouring MDTs to share practice was recommended.

Recommendation 6, for quoracy to be measured by specialism rather than individual attendance was noted, as was the need to ensure that an MDT member who knows the patients being discussed is present whenever possible. This would be most appropriate for the oncologists, radiologists and pathologists who are required to attend multiple MDTs.
Recommendation 7, that accountability and responsibility for treatment decisions lies with the clinician and patient, taking into account MDT recommendations, recognises that decisions may change in light of additional information gathered in clinic that was not known at the time of the MDT. The majority of changes were thought to be related to patient choice.

Recommendation 8, to audit implementation of treatment decisions versus MDT recommendations could be undertaken, as could Recommendation 9, to feedback surgical and oncological mortality and morbidity outcomes to the MDT.

Recommendation 10, for the MDT to actively manage and streamline the patient pathway, is attempted by trying to automatically generate appointments with medical and clinical oncology post MDT discussion. This would be more effective if sufficient appointment slots were available. TST hold a results clinic following the MDT which helps to streamline processes.

The responsibility for overall management of complex patients, who may be seen across multiple MDTs, needs to be clarified on cross-referral pro formas, to ensure that all necessary steps are actioned in a timely way. The importance of this from a patient experience perspective was emphasised by the user representative members of the group; patients need to know who they can contact for support at this stage.

Discussions of cases on standard pathways could be streamlined, and MDT lists checked to remove unnecessary repeat reviews to ensure that there is enough time to discuss complex patients.

It was important to keep discussion of research a priority on the MDT agenda.

4. Clinical guidelines

4.1 Biennial review of SWAG Clinical Guidelines

A request to change treatment of micro metastases in axillary lymph nodes to treatment of macro metastases was accepted. A request to change margins around ductal carcinoma in situ from 1mm to 2mm would not be made; 1mm margins are recommended by the current international guidelines. The margins for invasive disease will be clarified. The guidelines will be updated accordingly and made available on the SWCN website.

The SWAG guidelines recommend symmetrising surgery for breast cancer patients; this is not currently commissioned with parity across the region. Guidelines from the National Institute for Cancer Excellence (NICE) Cancer Action Board are due to send a document supporting commissioning of symmetrising surgery and this will be fed back from the SWAG SSG to the relevant commissioning groups.

The purpose of the site specific group, which was to ensure equity of access to best practice by dissemination of information, working with patient representatives to improve the patient experience, audit services, provide educational opportunities and peer support, promote clinical trials and sharing best practice, was re-clarified. SSG members are to recommend guest speakers to be invited to the next meetings. The
recently formed Cancer Alliance Board is committed to seek the advice of the site specific groups to drive the cancer agenda, creating a new opportunity to influence service development from a clinical perspective.

5. Living with and beyond cancer (LWBC)

5.1 Implementation of the Recovery Package

Please see presentation uploaded on to the SWCN website

Presented by Dorothy Goddard (DG), Chair of the SWAG Cancer Alliance LWBC group

The LWBC group has, where possible, introduced the elements of the recovery package into practice across the region, with comparable success in relation to other regions. NHS England, having recognised the need to change processes in response to increased survival rates and limited resources, has instructed commissioners to support the initiative, and invited Cancer Alliances to bid for Cancer Transformation Funding to incentivise the change (for submission by September 2017), with the aim for it to be fully embedded into practice by 2020. A proportion of the funding initially allocated has been redirected to focus on improving the 62 day cancer waiting time target by employing a transformation task force. The remaining funds will be used to train and recruit Band 4 support workers to assist the CNS teams, and to provide IT infrastructure for remote surveillance. The bid includes provision of support for psychological training.

NHS England aims to develop an information portal so that patients can access their results online, and potentially enter quality of life metrics; the SWAG CA has volunteered to pilot this scheme. There was concern that viewing results prior to discussion in clinic could have a negative impact on the patient experience. Development of a portal called Black Pear for this purpose was already underway in primary care; development of an additional portal could result in duplication of work.

The treatment summary templates will be uploaded onto Trust document management systems (for example, Big Hand).

6. Research

6.1 Clinical trials update

Please see presentation uploaded on to the SWCN website

Presented by David Rea (DR)

Recruitment figures, open trial and trials in set up are documented within the presentation. Recruitment was exceeding the expected target. A spreadsheet of all the trials available across the region, including Taunton and Yeovil, will be distributed. It was increasingly important to demonstrate that the NHS can conduct effective research to be eligible to open trials run by the pharmaceutical industry, by reducing study set up time and recruiting within estimated times and to target. It would be ideal if expressions of interest for rare cancers could be formulated as a network group. Recruitment could
then be sourced from across the region and the centres in which they open could be rationalised.

SSG members are to contact DR if they would like to undertake training on use of the online resources for research. Centres where recruitment is successful will be identified in order to share best practice, study set up time will be improved, as will timely upload of data, and the CRN will liaise with Research and Development departments regarding required resources.

It has been agreed to exclude rare disease studies from performance metrics.

The omission of studies in set-up from centres other than UH Bristol, and the inclusion of recruitment figures from the Spire hospital will be investigated.

7. Quality indicators, audits and data collection

7.1 Switching to sub-cutaneous trastuzumab administration: quantifying the benefits

Please see presentation uploaded on to the SWSCN website

Presented by Pippa Lewis

An twelve month audit of subcutaneous Herceptin (August 2015-2016), undertaken in RUH, showed a significant financial and practical advantage to the RUH Oncology outpatient department in comparison to intravenous administration, demonstrated by the following results:

- Financial saving of almost £100,000 over a 1-year period (does not take into account financial benefits of saving staff time)
- Significant savings in chair, administration, and pharmacy time
- Frees up staff and increases availability of chair space for other patients
- Lack of adverse reactions to sc trastuzumab in the 6-hour observation window.

It was concluded to be safe to recommend reducing the 6 hour observation window to improve the patient experience and increase the efficiency of the service; this could increase the financial saving by further reducing chair-time.

The results should be considered in the context of the potential cost savings to be made from biosimilar products, which could be less expensive, but administered via intravenous infusion, which has an increased acute reaction rate and is not the patient’s preference.

7.2 Network audit

SSG members are to email suggestions for network wide audits to the Chair.

8. Patient experience

8.1 CNS update
Taunton has experienced delays receiving the radioisotopes required for detection of sentinel lymph nodes (SLNs) on the morning prior to the scheduled biopsies. It was recommended to administer a double dose the day before biopsy at the centre most convenient for the patient. The experience of using Sentimag to detect SLNs varied across the region. It was essential to keep supplies of blue dye available; there was currently a national shortage.

9. Any other business

The problems with consent and pathology time associated with the 100,000 Genomes project required further discussion; Programme Manager Catherine Carpenter Clawson will be invited to attend the next meeting.

Date of next meeting: Friday 2\textsuperscript{nd} February 2017

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