

## Breast Cancer Pathway Board – Minutes of Meeting

Wednesday 10<sup>th</sup> July, 2 pm – 5 pm  
Seminar Room 1, Mayo Building, Salford Royal Foundation Trust

<b>Attendance</b>	<b>Representation</b>
Jane Ooi	Chair
Mohammed Absar	Trust Representative (Pennine)
Vanessa Pope	Trust Representative (Mid Cheshire)
Chandeena Roshanlall	Trust Representative (East Cheshire)
Zahida Saad	Trust Representative (Salford)
Amir Sharif	Trust Representative (Stockport)
Mark Pearson	Histopathology Representative
Anne Armstrong	Medical Oncology Representative
Brian Magee	Clinical Oncology Representative
Nigel Bundred	Trust Representative/Research Lead
Clare Brearley	Allied Health Professional
David Makin	Patient Representative
Karen Livingstone	Allied Health Professional
Amar Deshpande	Trust Representative (WWL)
Melissa Wright	Pathway Manager
<b>Apologies</b>	
Gillian Hutchison	Radiology Representative
Anthony Maxwell	Screening and PHE Representative
Coral Higgins	Commissioning Representative
Tarek Baht	Primary Care Representative
Amanda Myerscough	Primary Care Representative
Miles Howe	Histopathology Representative
Michael Crotch-Harvey	Radiology Representative
Tara Breslin	Primary Care Representative

Agenda Item	Action
<p>1. Welcome and Introductions</p> <p>JO welcomed everyone to the meeting and apologies were noted</p>	
<p>2. Working group sessions</p> <p>Members then divided into their working group areas (data, education/engagement event development and clinical guidelines) from 2-330pm.</p>	
<p>3 Feedback from the working groups</p> <p><b>Data</b></p> <p>This group identified several items of data that they thought would be useful to collect to inform the Pathway Board and to benchmark the performance of current services. It was recognised that due to some of the transition issues that have occurred nationally within health care, collection of some of this data may be a work in progress. The data would reflect different points in the pathway:</p> <ul style="list-style-type: none"> <li>a. Access to services - this would include screening uptake and where cancers diagnosed through this route were being treated as well as the case mix in regards to patients identified via screening or through symptomatic routes by Trust. This group identified that they would also like to collect data on adjuvant investigations and staging.</li> <li>b. Treatment data, this would include mastectomy rates and numbers of patients who had breast conserving treatment, as well as reconstruction rates. It was felt that adjuvant treatments and treatments complications outside of surgery including neutropenic sepsis rates, radiotherapy rates and other neoplasms caused by radiotherapy were important to understand. In addition data on positive rates for sentinel lymph nodes was also identified.</li> <li>c. Survival data, this would include 1-year survival rates and National Cancer Patient Experience Survey.</li> <li>d. The working group highlighted that specific audits may be required where data wasn't available to capture certain concerns regarding access to service provision. Access to physiotherapy was given as an example.</li> </ul> <p>Three priorities for collection were agreed. These were 2 week wait referrals and conversion rates; screening coverage and uptake; and stage of cancer at diagnosis. ZS also identified that the group wanted to ask each Trust to audit for surgical infection rates, haematoma and returns to theatre. JO explained that this data is entered into Somerset and it is the responsibility of each Consultant to enter this data if any complications arise. It was also noted that this data would be included in the dataset for surgeon outcome reporting. NB suggested that each Trust provide 1-, 3-and 5-year retrospective data on cancer patients to Tony Moran, a Consultant in Public Health at Public Health England. This would provide data on survival rates and staging.</p>	

## Education/engagement event

The working group identified several event ideas. These included:

- a. GP referrals, with particular emphasis on breast pain and benign breast disease
- b. Surgical management and post-operative complications. This would include how these should be managed in the community, reflecting on day case surgery and the support required for early discharge.
- c. GP referrals regarding patients with the symptoms suggestive of metastatic disease, along with the management of metastatic disease.
- d. Living with and beyond cancer to include input from a breast care nurse representative

The working group proposed 2 ways of developing these events. They included a large sponsored event where presentations could be held on all of the above. It was recognised that this would require significant organisation. The other suggestion was to hold 2-3 different events using the GP education events that are already established, where attendance is mandatory. JO explained that Manchester Cancer has a new strategic partnership with the Christie School of Oncology and this will include support in the organisation and development of the education/engagement events Pathway Boards are required to host. To develop separate events across the sector may be labour intensive. NG thought it would be useful to speak to Ged Byrne at NHS England Education who would have access to post-graduate education funding.

## Clinical guidelines

The group agreed a way forward in regards to developing the guidelines.

- a. CR network guidelines from 2012 would be reviewed and updated
- b. To support the review process, the chapter headings from the London guidelines would be used
- c. There would be named author leads for each chapter under review
- d. The overall format structure would be created for authors to enter their chapters into
- e. References will be the responsibility of each chapter author

JO felt that the guideline documents needed to be ready within a year. VP thought there should be a working document within 6 months, which would include MDT guidelines. JO explained that Manchester Cancer has a website and key documents would be available from there. BM asked whether there would be a genetics chapter in the guidelines and JO felt that someone could be co-opted to support the development of this.



	AHP representative
<p><b>ACTION: AHP update to be reported into Pathway Board</b></p> <p>7 Manchester Cancer User Involvement event feedback</p> <p>DM clarified that Manchester Cancer Provider Board had taken steps to develop patient engagement, in line with key guidance including ‘About you and because of you’ and it was also felt this work could have been more effective under the old Network groups. The user involvement event had been supported by Macmillan, who had identified the patients to attend the day. DM explained that a theatre group were used to simulate patient experiences, based on feedback from received from patients. DM highlighted that there were 20 patients who attended, and felt that this was disappointing as this number wouldn’t be enough to support all the Pathway Boards.</p> <p>JO explained that a summary of the event was provided by Manchester Cancer and highlighted that the next step would be to develop a framework document that would support Pathway Directors in identifying and supporting suitable patient representatives and managing their expectations. NB thought that breast care nurse could support Pathway Board in identifying suitable patients. CB explained that some patients would like to become engaged, but as they go along their treatment pathway, it becomes less appropriate. NB thought it would be useful to have a breast cancer user group, whose members would be selected to attend the Pathway Board.</p> <p><b>ACTION: PB to wait for the development of the patient engagement framework before identifying patient’s representatives.</b></p>	<p style="text-align: center;">Pathway Board</p>
<p>8 Mapping of breast cancer follow-up</p> <p>JO explained a piece of work that CH had suggested the Pathway Board engage in around follow-up. This would be on behalf of the MCIP project and would involve mapping follow-up activities across the region. NB explained that the MCIP project is looking to discharge patients to nurse-led follow-up and that further roll out of this pilot would be dependent on how well this is done in the City of Manchester. CB identified the difficulty of this project would be limiting the activity of this project to a small catchment area and this may be difficult to manage. JO explained that there were similar problems linked to the age extension screening roll out. MW asked if there was a questionnaire available to send out to Trust representatives. JO explained that CH would need to provide this. NB thought any survey should ask how patients access back into follow-up post 5 years.</p>	
<p>8. A.O.B.</p> <p>JO explained that she had received most of the returns for the radiology workforce questionnaire apart from UHSM. JO explained that the workforce issues facing radiology had been raised at a local and national level and she would also be contacting the local deanery to ask them to acknowledge the need to get placements within breast as a radiology speciality. NB explained that Ged Byrne has been approached by NHS England to develop a training programme, which would include breast radiology including training for ancillary staff.</p> <p><b>ACTION:</b> <b>JO to contact Ged Byrne</b></p> <p>BM explained NHS England had taken the decision not to fund Oncotype DX from 1<sup>st</sup> September. NB identified that NHS England had calculated that it was not cost effective to fund this as only 10% avoided chemotherapy with the test. NB thought that data from the Christie could be provided to NHS England to highlight that more than 10% of patients are avoiding chemotherapy. This data would be required by early August as there will be a meeting in September to decide whether this decision</p>	<p style="text-align: center;">JO</p>

## Manchester Cancer

<p>would be carried forward. MP asked whether the NICE guidance on a 4% threshold would continue and NB highlighted that it would. All Trusts identified that they had been using Oncotype DX on a regular basis.</p> <p><b>ACTION: Data from to be sent to NHS England.</b></p> <p>AS asked whether there could be symptomatic radiology representation on the Pathway Board as there have been concerns raised regarding their activity. AS explained they would like the opportunity to be represented within the Pathway Board and provide their perspective. JO explained that the remit of the group was wider than radiology and needed to focus on patient pathways and representatives should not be divided between symptomatic and non-symptomatic units.</p> <p>JO indicated that going forward if members were absent for 2 consecutive meetings they would be approached by JO to discuss this with them and she would ask them to consider and evaluate their capacity to be a member of the Board. MP explained that he would need to miss the next 2 Boards as he has received a summons to go to court.</p>	<p><b>BM/AA/NB</b></p>
<p>8. Date of next meeting</p> <p>Monday 8<sup>th</sup> September, 2 pm – 5 pm, room 2 , Musgrave House, East Wing, Royal Bolton Hospital</p>	