Manchester Cancer

Breast Pathway Board – Minutes of Meeting

Thursday 17th March 2016, 2pm – 5 pm
Rm222+223 Trust HQ, North Manchester General Hospital

Attendance	
Mohammed Absar	Pathway Director, Consultant Breast Surgeon, Pennine
David Makin	Patient Representative
Jo Taylor	Patient Representative
Gillian Hutchison	Radiology Representative for GM
Coral Higgins	Commissioning Representative, Manchester CCG
Claire E. Gaskell (CEG)	Breast Cancer Nurse, Christie
Clare Garnsey (CG)	Consultant Breast Surgeon, Bolton
Chandeena Roshanlall	Consultant Breast Surgeon, East Cheshire
Vanessa Pope	Consultant Breast Surgeon, Mid Cheshire
Susan Hignett	Consultant Breast Surgeon, Mid Cheshire (future delegate for VP)
Clare Brearley	Advanced Nurse Practitioner, Pennine
Anne Armstrong	Medical Oncology Representative, Christie
Michelle Leach	Macmillan User Involvement Manager, Manchester Cancer
Karen Livingstone	Allied Health Professional, Physiotherapist, UHSM
Nigel Bundred	Research Lead, Consultant Breast Surgeon, UHSM
Vanessa Hickson	Macmillan Breast CNS, Tameside
Nicola Remmington	Pathway Manager, Manchester Cancer
Pardeep Arora	Consultant Breast Surgeon, Tameside (Replaced Mr Ellenbogen as Tameside Rep)
Apologies	
Mark Pearson	Histopathology Representative
Michael Crotch-Harvey	Radiology Representative, East Cheshire
Emma Reid	Radiologist, Stockport
Miles Howe	Histopathology Representative, UHSM
Amar Deshpande	Consultant Breast Surgeon, WWL

Agenda Item	Action
1. Welcome & Introductions MA welcomed everyone to the meeting. Apologies were noted. **i. User Involvement:** Michelle Leach (Macmillan User Involvement Manager for Breast) was welcomed to the Board (replaced Hannah Leaton). Michelle's contact details**:** T: 0161 918 2087, M: 07920817568, Email: Michelle.leach1@nhs.net **ii. Patient Representative**: Jo Taylor was welcomed to the Board. [Jo has set up a website to provide information to help those diagnosed with Breast Cancer make informed treatment choices]: http://www.abcdiagnosis.co.uk	
2. & 3. Working Group Sessions – Feedback **WORK GROUP 1** **Risk Reducing Mastectomy Pathway:** CR provided a summary stating that they have reviewed the draft guidelines and have now categorised patients into 5 groups: **i. Genetically Proven Breast Cancer** These patients should have had genetic counselling but it needs clarifying as to how this cohort of patients receive a psychological assessment as the referral route does not appear to be standardised across GM (probably referred by the Geneticist but this needs confirming). After this psychological assessment the patient is referred to their local hospital and offered various treatment options. **ii. Patients with a Family History of Breast Cancer** These patients will normally have been seen by a Genetic Counsellor, but if not, they would need a fast track referral to the Psychologist and this needs to be stated explicitly within the new guidelines. From the Psychologist the pathway would remain the same i.e. referred back to the local hospital for treatment options **iii. Family History of Breast Cancer but not gene proven** These patients need to receive a fast track referral to a Genetic Counsellor and to a Psychologist and this needs clarifying from Gareth Edwards as to whether this service will be provided. From the Psychologist the pathway is the same. **iv. Patients previously treated for Breast Cancer and wish for further preventative surgery** **v. Patients without family history and without prior breast cancer wishing for preventative surgery** Local units should have the facilities to quantify the risk of breast cancer within this cohort of patients. The literature supporting this needs to be reviewed (VH volunteered). Essentially, these patients should not be advised to undergo RRM but appropriate referral to Psychological support should be given. MA highlighted that there is an issue with Psychological Support resource across GM. CH stated that this needs a scoping exercise in order to confirm current resource capacity and location of resource. CG stated that the Psychological Support Group have completed such an exercise and she will contact them to request the data. DM stated that he will raise the issue of the lack of	**ACTION: VH to review data regarding risk quantifying for patients wishing for preventative surgery.**

Psychological Support resource at the next Provider Board meeting. **WORK GROUP 2** **Innovation in Diagnostic Pathway:** CG highlighted that at the last Pathway Board meeting they had discussed putting together a survey to establish a Benchmark for the Diagnostic pathway cross GM. However, they then established that the Association of Breast Surgery (ABS) had recently conducted such a survey nationally. CG contacted Maria Bramley (ABS Rep) to request the data but this will not be made available until after the ABS conference scheduled on 16th & 17th May 2016. For today's session the group focussed on **Breast Pain (without other symptoms)**. As all referrals are seen within 2 weeks for Breast services the aim was to review this. The most benign intervention would be to get GPs to complete a checklist (CH to liaise with Sarah Taylor, GP, who is working on the national referrals pathway) prior to referring and to document this. Concern with this is that previous GP education initiatives have been conducted covering this but there are still a high number of Breast referrals for breast pain only. CG stated that she has completed a local audit [Bolton] of 200 patients and found: • 30% of referrals had Breast pain with no other red flag symptoms • 20% of referrals were >40yrs old CG stated that the feedback she received from GPs was to clarify as to what exactly should a GP do when a patient returns after initial visit where the checklist was completed etc. as currently the only available option is to refer to secondary care. CG stated that 'straight to diagnostic tests' would be a step back but a suggestion may be to refer to a '**Mammogram only clinic**' (for patients >40yrs) in a similar way that follow-up was changed from clinical examination for ten years to 'Mammogram only'. The obvious problem with this is a lack of Radiologists and the possibility of increasing Radiology referrals. Bolton CCG has asked whether it would be possible to trial this as a 3 month pilot just using a few GP practices. NB stated that a pilot would be a mistake as 'direct to Mammogram' is not currently recommended and also, there is a risk of missing cancers through Mammogram only and therefore this should not be done. NB stated that the focus should be GP education and improved written information on Breast Pain for patients to be provided within primary care. CG clarified that patients >40yrs are already eligible for Mammograms but the idea is to eliminate the requirement for a Consultant referral as the patient is requiring reassurance that their breast pain is not indicative of Breast Cancer and despite robust literature etc. being provided many still require a mammogram to provide the reassurance required. NB still felt that this was not clinically safe and missed cancers would still be a possibility. The group agreed that his was not a viable option. MA stated that this topic will remain on the agenda for the next PB in order for further ideas to be developed. **WORK GROUP 3** **Data:** CEG summarised that the following areas need focussing on: • Standardising time for core biopsy results (including ER, PR and Her2). Ideally should be 3-4 days but at present between 3-10days. • Standardising time by which a patient should have their first MDT discussion. This is very variable at present. • By what time should the patients have their post surgery MDT decision and option of	**ACTION: CG to contact Psychological Support Group to request Psych Support resource data.** **ACTION: CG to forward ABS survey report once available to NR to share with PB.**

treatment? • Possibility of decreasing the 62 day target to 45 days by looking at the individual components (for 80%)? • Development of GM Audit of all units Include: - Pre-op diagnosis rate - Axillary Staging Ultrasound and Cytol rate - Margin involvement <1mm - Breast Reconstruction Rate and Implant Loss - 1, 3 and 5yr local recurrence rate and mortality - Late and distant recurrence rate - There are major differences in surgical removal or PET in the elderly ranging from 1%-25% in 1 screening unit. This translates into survival differences in the over 70s which is not optimal. CEG stated that it was imperative to cover areas of all of the pathway and not just Diagnostic and primary treatment. NB highlighted that within Scotland they collate such data nationally and as the data is collated by one group this ensure standardisation. NB will share last year's Scottish Audit. The group concluded that a **Data Manager role** (1WTE) would be required in order to effectively collate the required data across GM, potentially funded through the Cancer Vanguard Cancer Intelligence work stream. NB stated that his would be the only effective way to prevent and identify non-standard management patterns compared to Network or NICE guidelines and thereby improve outcomes.	**ACTION: NB to forward Scottish Audit data to NR to share with PB.** **ACTION: MA/NR to produce business plan to the Cancer Vanguard for Data Manager Role.**
4. Minutes of the previous meeting and matters arising **From previous minutes: 4 II** • **Letter of Concern to RCR:** As the response from RCR urged the Breast PB to write to Jacky Hayden of Health Education North West to share our particular concerns, a letter will be drafted and shared with the Board prior to sending. **Minutes were approved.**	**ACTION: MA/NR to draft letter to Jacky Hayden & share with PB prior to sending.**
5. Objective 1 – Improving outcomes/survival rates **a. Breast Cancer Annual Report and Plan** NR confirmed that he Annual report is due by the end of June 2016. MA stated that MA & NR will draft the report and this will be available to review at the next PB. CEG made the following observation that when reading the 14/15 report it doesn't give the impression that the Pathway Board is responsible for the whole pathway but rather just the diagnostic/surgery element and therefore an effort should be made to rectify this within the next report. CB also highlighted that all nurses within the 14/15 doc are referred to as AHPs when their appropriate title should be referred to in a similar manner to all other health professionals within the document. Both suggestions were acknowledged and will be adhered to when completing the draft Annual Report.	**ACTION: MA/NR to provide first draft of 15/16 Annual Report for next PB.**

Recovery Package - CB highlighted that the Nursing Workforce report has now been circulated showing the number of staff at different grades across the service in GM (including Physiotherapists and secretaries etc.). CB is collating a second part to this looking at the number of sessions staff spent on different tasks, however, this has proved difficult as Nurses do not work in sessions and work very ad-hoc and therefore this has been difficult for Nurses to translate into 'sessions' – CB should have this available for the next PB. CB highlighted that currently Bolton have a Breast Nurse on Zero Hrs Contract (Nurse recently retired and has agreed to work a Zero Hr Contract) which is working very well when cover is required for Annual Leave/Sickness as there is a Nurse able to cover who is familiar with the set-up etc. and could possibly be replicated across other sites. **b. Breast Cancer Quality Standards** MA discussed the current version of the draft Quality Standards which has been transferred to the format adopted by the Urology and OG services that have recently embarked on a similar service transformation process which included updating their quality standards. MA invited feedback from the Board. **c. Breast Cancer Dataset** Salford is still to provide data to NR, however, the analysis will now be completed without and presented at the next PB.	**ACTION: CB to forward second part of the Nursing Workforce Report once available to NR to share with PB.** **ACTION: All to review reformatted Quality Standards doc and forward comments to MA/NR prior to next PB.** **ACTION: MA/NR to analyse dataset and present at next PB.**
6. Objective 2 – Improve Patient Experience **a. MCIP Update** CH provided summary: **Breast Programme** Currently have three sub-groups: i. Recovery Package sub-group ii. Mammographic Surveillance sub-group iii. Pathways for people with Advanced Breast Cancer sub-group A Steering Group has also been set up. **The Recovery Package sub-group** are looking at all elements of the Recovery Package and looking at how to implement within the two Breast Services in Manchester. **Mammographic Surveillance sub-group** is focussing on the technical aspect of decoupling the Mammogram from the currently required outpatient appointment. Also looking at new pathways for monitoring and aftercare for different groups of patients. **Pathway for people with Advanced Breast Cancer sub-group** have developed a document defining all key roles and the interface between different teams therefore making it explicit as to when patients are referred to different teams across the service. MA highlighted that for the last six months the progress has been steady.	

b. Living With & Beyond Cancer Update: CEG stated that they have now collated all required data relating to Secondary Cancer for the Innovation Project and are currently analysing this and will present at the next PB meeting. NR further highlighted the request issued to the Pathway Board from the LWABC Pathway Board to complete a 'Late Effects' questionnaire. Previously minuted that all Trusts would have responded by the end of Jan 2016 but as yet only responses received from Bolton and East Cheshire. **c. AHP Forum Update** CB stated that the attendance for the last AHP forum at Bolton was poor and nobody from the PB had been available to attend. CB is still awaiting a copy of the minutes and therefore could not provide an update. Agenda Item to be carried over to next PB meeting. CEG highlighted that the AHP Forum meeting dates need to be scheduled for the year and shared in order to facilitate improved attendance. KL stated that currently there is a rolling chair for the meeting but this is not working well as the responsibility moves from person to person. CB stated that possibly this last meeting has been a blip as the attendance prior to this has been very good. MA stated that the group should try assigning a chair for six months duration to improve ownership and attendance. **d. Patient/User Communication** ML summarised the Q2 User Involvement report. ML stated that she had recently been successful in recruiting two people affected by Breast Cancer (Jo Taylor, present) and also a further representative who will be attending in the future (Victoria Yates). ML highlighted that the User Involvement Team now have resource of one hundred people affected by cancer and wished for all to keep this in mind and to tap into this resource for any future projects etc. ML stated that the group are currently very engaged but need to be utilised in order to sustain that level of engagement. DM highlighted that the User Involvement reps for each Board are to feed back to newly established small communities of people affected by cancer in order to ensure a wider representation of views. MA commended ML for the rate of achievement in recent months. MA highlighted that a further 'person affected by cancer' candidate had recently been interviewed. This candidate was unsuccessful due to the fact that she was a GP and would potentially be viewing things as a medic. However, it was felt that she would be a great benefit to the Board as an additional Primary Care representative.	**ACTION: CEG to present Secondary Cancer data (Innovation Project) at next PB.** **ACTION: All Trusts to complete LWABC 'Late Effect' questionnaire and forward to NR by end of Mar16.** **ACTION: ML to invite Anneela Saleem to join the PB as a GP rep.**
7. Objective 3 – Research and clinical innovation **a. Clinical Trials Update:**  rerun_BREAST_Trials_report_Q3FY2015-1 NB confirmed that Salford had previously not been present on the Trial reports due to having not recruited. NB stated that GM is the highest recruiter to Breast Trials however,	

there is disparity in recruitment across GM as there are a number of very high performers and others that are very low and we need to aim for all to at least attain the national average. MA commended NB and group for the **EPHOS Trial** results which were recently presented on the radio.	
b. 100k Genome Project: Jane Rogan [Business Manager - Manchester Cancer Research Centre Biobank] presented an update regarding the current position of the project and how the Breast Pathway Board can contribute going forward. NB highlighted that the extensive consent form would hinder recruitment logistically. CB highlighted that the £300 allocated per patient would not cover all recruitment costs. MA requested for all to feedback to their trusts and to endeavour to participate if possible.  Genome_update_-_100K_Genomes_Projec Jane Rogan stated that she would be happy to discuss details further and is willing to visit Trusts to address any queries etc. **Jane Rogan's contact details:** Tel: 0161 446 3659, Fax: 0161 446 3792, Mob: 07917 173490 Email: jane.rogan@christie.nhs.uk Website: http://www.mcrc.manchester.ac.uk/biobank	**ACTION: All to assess if viable to participate in the 100k Genome Project.**
8. Objective 4 – Improving and standardising high quality care across the whole service	
a. Radiology Update: GH stated that it is often overlooked regarding Sonographer/Mammographer and Advanced Practitioner resource issues as opposed to only Radiologists. Also, these areas are not represented on the Pathway Board.	**ACTION: MA to assess possibility of broadening Radiology representation on the PB.**
b. Pathology Update: MH not present. MH was to provide an update regarding the minimum number of specimens a Pathologist should be required to review and whether there should be a distinction between screening/symptomatic (National Co-ordinating Committee for Breast Pathology). Deferred to next meeting.	**ACTION:MH to provide update regarding Pathologists required minimum specimen review rate.**
c. Paediatrics in Breast Clinics Guidelines Update: VP stated that she had received some concern regarding evidence to support using Tamoxifen. The Board agreed that this should be removed from the guidance. Guidelines were approved by the group. NR to upload amended guidelines to MC website.	**ACTION: NR to upload amended Paediatric guidelines onto the MC website.**

9. Any Other Business **a. Cancer Vanguard Update:** MA stated that the hope for the future is to attain more robust data through the Cancer Vanguard Cancer Intelligence workstream and associated pilots. NR stated that a representative from the Cancer Vanguard team will be attending the next PB to present the current position and answer any questions/concerns. **b. Audit Programme:** CH requested confirmation that there would be an established Audit Programme going forward. MA confirmed this to be the case and stated that this would be explicitly stated within the Annual Report as an objective for 15/16.	
10. Date of next meeting: Wednesday 18th May 2016 2pm – 5pm Trust Meeting Room 6 Trust Admin The Christie	