GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Breast Pathway Board

Breast Pathway Board

Minutes and Actions

Wednesday 12th September 2018

2.00pm – 4:30pm

Meeting Room 6, 3rd Floor, The Christie, Wilmslow Road, Withington, M20 4BX

In attendance

Name	Role	Breast Cancer Pathway Representation
Mr Mohammed Absar (MA)	**Consultant Breast Surgeon**	**Chair and Trust Representative, Pennine**
Rachel Allen (RA)	Pathway Manager, GM Cancer	
Carolyn Walker (CW)	GP	Primary Care Representative
Charlotte Lomax-Moore (CLM)	Macmillan Breast Specialist Nurse	MFT
Claire E Gaskell (CEG)	Macmillan Secondary Breast Cancer Nurse Specialist	
Clare Brearley (CB)	Advanced Nurse Practitioner	NCA
Coral Higgins (CH)	Cancer Commissioning Manager, NHS Manchester Clinical Commissioning Group	Commissioning Representative
Deborah Watts (DW)		Patient Representative
Dr Gillian Hutchison (GH)	Consultant Radiologist	Radiology Representative
Fiona O'Regan (FOR)	Macmillan Lead Nurse, MFT	Trust Representative, MFT / Nightingale Breast Unit
Joanne Taylor (JT)		Patient Representative
Karen Livingstone (KL)	Specialist Breast Care Physiotherapy	
Mel Atack (MAt)	User Involvement Manager, GM Cancer	
Miss Chandeena Roshanlall (CR)	Consultant Breast Surgeon	Trust Representative, East Cheshire
Miss Clare Garnsey (CG)	Consultant Breast Surgeon	Trust Representative, Bolton
Miss Vanessa Pope (VP)	Consultant Breast Surgeon	Trust Representative, Mid Cheshire
Mr Amar Deshpande (AD)	Consultant Breast Surgeon	Trust Representative, WWL
Mr Gerard Lambe (GL)	Consultant Plastic & Reconstructive Breast Surgeon	Trust Representative, The Christie
Ms Nabila Nasir (NN)	Consultant Breast Surgeon	Trust Representative, PAHT
Prof Nigel Bundred (NB)	Consultant Breast Surgeon	Research Lead
Vanessa Hickson (VH)	Macmillan Breast Clinical Nurse Specialist	Trust Representative, Tameside
Victoria Yates (VY)		Patient Representative

Guests present

Melanie Owen (MO)	Pfizer	
Stephen Cartwright (SC)	Patient Experience Manager, Pfizer	
Lisa Edge Davies (LED)	Patient Experience Manager, Pfizer	
Lindsey Wilby (LW)	Programme Lead for Living with and Beyond, GM Cancer	
Lenny St John (LSJ)	Transformation Project Manager	Tameside & Glossop ICT

Apologies

Amanda Snippe (AS)		
Dr Emma Reid (ER)	Consultant Radiologist	Trust Representative, Stockport
Mr Richard Johnson	Consultant Breast Surgeon	Trust Representative, UHSM
Nikitas Dimopoulos (ND)	Consultant Breast Surgeon	
Anneela Saleem	GP	Primary Care Representative
Dr Anne Armstrong	Consultant in Medical Oncology	Oncology Representative
Dr Miles Howe	Consultant Histopathologist and Pathology QA Lead	
Dr Vivek Misra	Consultant in Clinical Oncology	Oncology Representative
Kathryn Place	Macmillan Transformation manager (Living With & Beyond Cancer)	WWL
Mr Pardeep Arora	Consultant Breast Surgeon	Trust Representative, Tameside
Mr Sumohan Chatterjee	Consultant Breast Surgeon	

1. Welcome and introductions

MA opened the Board and welcomed attendees.

2. Minutes of the last meeting (2nd July 2018) and matters arising

Discussion summary	Minutes of the last meeting were reviewed. Members requested the following changes to be made: • Chandeena Roshanlall (CR) to be noted as present • Vanessa Hickson (VH) to be noted as present • Amanda Snippe (AS) to be noted as present • Claire Garnsey (CG) raised the concerns around the DIEP service issue, not Clare Brearley (CB). Correct CB to CG. • [Email received from Mr Nikitas Dimopoulos (ND) requesting that concerns expressed in relation to the transformation model, the standards document and the transition period towards the implementation of the new service model are included in the minutes]. Text inserted into minutes 2nd July minutes: *Theme 3 reconfiguration was discussed and members felt that their comments during the Theme 3 visit were not properly received and reflected in the document presented to the Board. The paper was shared with the Theme 3 Board without prior sign off from the Breast Pathway Board or Trusts.*

	• [Email received from Anne Armstrong highlighted the she was present at the July Board]
Conclusion	Other than the agreed changes, the Board accepted the minutes as an accurate record of the meeting.
Actions and responsibility	**RA to revise the 2nd July minutes accordingly.**

3. Pfizer

Discussion summary	Stephen Cartwright (SC), Melanie Owen (MO) and Lisa Edge-Davies (LED) from Pfizer were welcomed by the Chair. Pfizer have developed an initial draft project offering the provision of project management support in relation to the metastatic breast cancer pathway in GM. MA explained that the intention of their visit was to gather the Board's input into what is required to enhance the metastatic pathway for patients in GM. MO, Health Care Development Manager for oncology opened the presentation on behalf of Pfizer. MO explained that the team work specifically on breast, renal and lung at present. The team have worked with GM, The Christie and other trusts across the country previously. MO highlighted that they have delivered 23 projects over 6 years which are shareable to the Board if useful. MO articulated that Pfizer are keen to get input and help in terms of what the Board sees as a need in GM to improve the metastatic pathway. Pfizer's ideas came from some initial discussions with clinicians around the services for metastatic breast cancer and the variation that exists across GM. MO explained that Claire O'Rourke (COR) was keen from a GM perspective to look at metastatic breast services across GM and try to understand the needs of patients. MO explained that the team have an idea of what they think the challenges are. They are keen to understand the Board's thoughts. Identifying robust data as a baseline would be key initially, then 'the skies the limit' in what the potential solutions could be. LED and SC are interested in potentially looking at what AI technology is available depending on what the challenges are further down the line. LED explained that she is a patient experience manager with SC. They work across oncology particularly between Pfizer and the NHS looking at where they can support with essentially business problems and look to make recommendations, which could be technology solutions or service redesign. In this instance, they would work with GM Cancer, giving their time,

	contracted to GM with SC and LED assigned as project managers. LED outlined that she is keen to understand who would need to be involved from a project board perspective. If commencing with analysing what the current situation is in GM for patients with secondary breast cancer [as proposed], who would need to be involved so that they can begin to shape the project. MA expressed that the Board have been looking at the metastatic pathway for a long time and how it varies between CCGs, and how patients are not treated in the same way as a primary breast cancer. CH was invited to share practice from her [commissioning] perspective and described some of the variation across the city with examples from Pennine and the South. The Board advised that breast units would be key stakeholders. Macmillan mapped out the pathways for advanced breast cancer in Manchester so would be good initial contacts to help understand the pathways. CEG was partly responsible for writing the advanced breast cancer pathways. This approach would then help to realise the differences between some of the outlying hospitals outside the city of Manchester. LED is keen to understand what data is in existence already as through initial conversations wasn't sure that a baseline currently existed. It is encouraging to hear that there may be a baseline already through the MCIP programme. It was noted through Board members that a mapping exercise undertaken through the Christie [via CEG] had been undertaken but it doesn't encompass a wider GM population. Board members proposed to start with the work that CEG has undertaken at The Christie and mirror it. There was a suggestion to analyse the data collected at The Christie, assess whether it is relevant and then gather a comparison from local breast units. LW highlighted that currently, the total number of metastatic patients across the region is unknown. CEG agreed and outlined that there isn't a way to identify the population. LW suggested asking the individual teams in the region to see if they would know the population size. CEG indicated that individual teams wouldn't have this information although referenced that Pennine have been collecting data. It was noted that national work is underway to look at the pathway but it will take time. It was noted that JT has been advocating for this. CEG confirmed that she is happy to help and suggested for regional teams to map out what they know about who they are seeing and who they think they aren't seeing. CEG commented that some teams don't see metastatic patients at all. The Pfizer team explained that the mapping would be the first phase of work, but then the team are keen to look at what the Board see as the optimal

	metastatic service. The Pfizer team commented that they anticipate that the ambition is for patients to be cared for closer to home; allowing good quality of life for longer is a massive priority. Building on from work of supportive self-management, the team enquired whether there was any reason that that work can't be rolled out for metastatic patients. CEG responded that it depends on the stage of disease. It is much more complicated to stratify for a metastatic patient than it is for primary. In GM, the stratification is nursing stratification instead of what is used on the primary side which is more medical stratification. The risk stratification is based on the histology and the ability of the patient to self-manage. It started out as based on tumour size; however it is now on the patient's ability to self-present. LW highlighted that patients need to access that a broader range of support. For example, patients who come to The Christie don't just get treatment; they get access to metastatic breast cancer team who provide a suite of support in various forms. MO highlighted the lack of knowledge/data to indicate whether such an approach is sustainable across the 10 regional units and the need to find out. CG queried Pfizer's involvement. The Pfizer team explained that the proposed project came from conversations with clinicians and CoR. The Pfizer team support sustainable cancer services and can help with resource to facilitate change. All data will come back to the Board. Pfizer will not see any patient identifiable data. The only way Pfizer will see the patient view point will be through MAt. The Pfizer team clarified that once the data has been analysed through the mapping exercise, the idea is to make change by looking at solutions. LW highlighted that anything Board members can do to identify those gaps and pull the data together from what is already beginning to be captured will be essential. Timescales were discussed briefly. The intention is for LED to visit the Trusts and pull a wider GM event/briefing together in the coming months.
Conclusion	Pfizer are proposing to offer resource to examine the current metastatic breast cancer pathway across GM (within each Trust), along with aggregating available data around demand for services, present a series of recommendations to the GM Breast Pathway Board. This will be undertaken as a project with Pfizer providing project management support. The Board expressed their support for the project. It was agreed that LW will be the point of contact going forward from a GM Cancer perspective. Key stakeholders have been identified to advise and inform Pfizer on their

	intended approach with a view to organising a meeting of broader stakeholders in a few months' time. Key stakeholders agreed as: • MA • Members of the Breast Board who were part of the MCIP Programme during its existence • Representatives from each of the trusts (probably the lead CNS) including the Cheshire Trusts • CEG • A patient representative • Richard Clapham (RC) • The Christie's secondary breast cancer focus group • GP input • LW (who will lead on behalf of GM Cancer) Initial work can be undertaken electronically, rather than face to face. Timescales for this project are still to be agreed formally.
Actions and responsibility	**a) Pfizer team to revise the project brief and seek approval from key stakeholders. Once this is signed off, GM contact details can be shared with the Pfizer team.** **b) Representative from each Trust to be nominated to RA by end of September.** **c) RA to collate a list of individuals for Pfizer to begin making contact with (as outlined above).** **d) MAt to invite JT to be involved in this project going forward.** **e) VH to communicate with her CNS and nurse group that this work is about to be undertaken.** **f) Pfizer team to organise a meeting of broader stakeholders circa November 18.**

4. DIEP update and plans

Discussion summary	The DIEP service was discussed. In summary, executive discussions are ongoing between MFT, Greater Manchester Cancer and The Christie. An update will be provided at the November Pathway Board.
Actions and responsibility	**a) MA to keep the Board informed of progress in resolving the issue.**

5. Subgroup feedback

5.1. Service improvement subgroup (SI subgroup)

Discussion summary	CH (co-chair of the SI subgroup) updated on the work of the committee. The group have been looking at creating documents to help local breast units as they implement the recovery package and move towards supported self-management. One of the documents that the group was tasked with was scoping the consequences of treatment and then the different pathways that exist. The paper is almost complete however the Cheshire Trusts have been missed off accidently so will be revised. CH expressed apologies to VP and CR. CH informed that brief guidelines around telephone triage to support ladies who wish to re-access the service have been developed. VH will send to the CNS and AHP group for comments. Re-access guidelines have also been produced, who will be seen, what time etc. VH will also seek comments from the CNS and AHP groups. CH informed the Board that discussion took place with LSJ on HNAs and network guidance from GM Cancer that there should be two HNAs completed as part of the recovery package, one pre-treatment, one post-treatment. CH continued that talking to clinical colleagues, the pre-treatment HNA isn't always appropriate because of the timing of diagnosis and getting patients into treatment. To give LSJ some assurance on the policy of this Pathway Board, the subgroup have been asked to produce a short policy on the reasons that this agreed approach. The SI subgroup will pull that together. VH highlighted that it will be described as robust, comprehensive and addressing patient concerns. MA mentioned that NHS guidance states that everyone should have a HNA. CB commented that all patients have a treatment summary appointment; just because they are not having a formal electronic HNA does not mean that they are not having a holistic needs assessment. FOR highlighted that this has been practice for many years and that the problem is that it's not being recognised as a formal HNA. LSJ highlighted the need to understand whether two HNAs are compulsory even if it is not necessarily appropriate for the patient. LSJ needs to be assured that it's now out of scope and therefore shouldn't be counted. It was suggested for a position statement from the Breast Pathway Board to address the concerns that this inconsistency will raise, i.e. because the HNA is not electronic, it will show as a zero return for every breast unit in the region. MA asked how we can overcome this. There was discussion as to the appropriateness of a formal HNA for all patients. VY highlighted that patients may not be in the headspace for a formal HNA unless something triggers it at that point of time e.g. fertility. MA highlighted that GM Cancer will not agree to allow GM to not comply with HNAs as the rest of the country are undertaking them. Fiona confirmed that in GM they are being undertaken but *when* they get it

	varies. CB highlighted that it's more a problem with how GM Cancer are collecting the data. Everyone who has a treatment options appointment is having a HNA. MA agreed and said that that needs to be documented. LSJ highlighted that this is the first step in supported management so the idea that it has been completed has to be written up and shared with the patient.
Actions and responsibility	**a) CH to send the consequences of treatment document back out to VP and CR to add the information for the Cheshire trusts. Once updated, CH will send to RA who will share with the Board.** **b) VH to send brief guidelines around telephone triage to support ladies who wish to re-access the service to the CNS and AHP group for comments.** **c) VH to seek comments from the CNS and AHP groups on the re-access guidelines.** **d) SI subgroup to pull together a position statement on HNAs for the Breast Pathway and share at the next board in November.**

5.2. Research and innovation group (R&I subgroup)

Discussion summary	CG (chair of the R&I subgroup) spoke about the work that the group have been undertaking to improve communication about research and innovation around the region. CG informed the Board that the sub-committee have almost finished the network of contacts. RA and CG are going to meet to finalise that as RP has moved on and it was one of her actions. The second item was the pan-GM research strategy. The first aim of this was to work out if variation exists in what patients are being offered in terms of research around GM. The subgroup has designed a questionnaire which is now complete. This will be sent out in the next couple of weeks to the research nurses. If there is a problem with reaching the research nurse, the trust representative will be contacted. The data will then be analysed. A paper will be produced by the subgroup to indicate whether there is, or is not variation in research resources around GM and that will be used by CCGs and others to work out next steps. The third item was the mapping of oncoplastic practice which will then be fed back. The final item discussed was The Christie research page for patients to see what trials are available. The subgroup felt that it was an effective and impactful website so the group will look into it further and will bring information back to the next Board in November. The subgroup need time to check their oncologists are happy for it to be cascaded through a variety of channels including patient forums. NB highlighted that research nurse time is paid for by the Comprehensive Research Network and is nothing to do with GM as per se commissioners.

	NB continued that funding comes from the national comprehensive research work so is paid on the basis of recruitment and activity. It's not something that comes from commissioners in GM. CG commented that the Board still need to look at whether there is variation in resource around GM. CG clarified that resource isn't just research nurses, it includes other things that enable recruitment to trials such as the strength of the R&D department, whether there is an adequate number of radiologists, whether there is adequate administration support, whether research nurses share tumour groups and can attend the MDM, and the regularity of research meetings. NB noted that every MDM should have a research lead, not necessarily a research nurse. CB continued, there is clearly variation in recruitment due to variation in resource. The subgroup will look at reasons as to why this may be the case.
Actions and responsibility	**a) RA and CG to meet to finalise the work around improving communication about research and innovation around the region. RA to pick up outstanding actions previously assigned to RP.** **b) CG and colleagues to disseminate questionnaire (to assess variation in patient research opportunities across GM) to research nurses in the next couple of weeks. If there is a problem with reaching the research nurse, the trust representative will be contacted to action this.** **c) CG and colleagues to analyse the data collected and produce paper to indicate whether there is, or is not variation in research resources around GM. This will be used by CCGs and others to work out next steps.** **d) Subgroup to look into The Christie website research page and bring information to the next Board in November.**

5.3. Data collection and review subgroup (DCR subgroup)

Discussion summary	VP (chair of the DCR subgroup) informed the Board that James Leighton (JL) has retired but this had not been communicated. James was tasked with identifying some key datasets. RA updated that we have a GM Cancer analyst, Morris Tomlinson (MT) and a wider team of analysts in post. RA offered to connect with Morris and identify the missing data. VP informed the Board that the group have initiated a new audit of 2 week waits as its becoming a struggle to see everyone within 2 weeks. The number of referrals and number of inappropriate referrals are increasing. The group are planning to audit against NICE guidelines and pull together an audit proposal which can be piloted in one site, possibly at Crewe and then potential roll out can be explored. It will require somebody to look at notes at the end of each clinic. VP informed the Board that the subgroup is hoping to

	have progressed this for the November Board.
Actions and responsibility	**RA to connect with MT and identify the missing data that was tasked to JL prior to his retirement.**

5.4. Clinical trials recruitment

Discussion summary	NB shared the latest figures for breast clinical trials recruitment. NB explained that for many years [Greater] Manchester was at the top for clinical trial recruitment in breast cancer. Currently it's in fifth place. Recruitment across the networks and by trust was presented. The number of studies open was discussed. NB explained that it's varied in GM. It isn't happening in some trusts. NB described recruitment to Add-Aspirin, and commented on the very little recruitment in Pennine and South Manchester. Add-Aspirin is one of the biggest trials we have in GM. JT asked whether it was because clinicians aren't inviting patients to the studies. FOR queried the source of the figures and commented that MFT are recruiting to Add-Aspirin. NB explained that they are current figures from 1st April 2018, to date (w/c 4th September), four months' worth of data. NB commented that last year, GM were the third highest recruiting network and the year before, the top. FOR highlighted that there was a period of time at MFT where there were no research nurses in post. NB accepts this. FOR highlighted that at one point, the service was manned by one research nurse at MFT. NB highlighted that the agreement was that approximately 50 patients would be recruited to one nurse over the course of a year. All research nurses should be recruiting. If they are working in more than one area than breast alone, it will be 50 patients across all tumour sites that they are working in. These are the current figures. NB described another example, MAMMO-50. NB outlined that MFT had recruited no patients, only one in Pennine and none in Stockport. FOR highlighted that MFT are looking into MAMMO-50 but staffing is a massive issue. CB highlighted that there are so many contributory factors, as previously outlined, which is why CG needs to undertake the assessment of resource. FOR highlighted that PRIMETIME has been recruited to well in the South. VH highlighted missing patients for the Family History Lifestyle Study at Tameside – they actually had 7 recruited to the trial. NB highlighted some may not have been registered if observational studies. VH highlighted that

	POSNOC would not accept Tameside patients. NB referenced that every R&D nurse has a target to achieve every year. R&D is performance monitored. FOR commented that the breast research team at MFT have got half the staff as when they were top of the league two years ago. The patients are identified at the MDT with the consultant and the research nurses get involved – the pathway is followed exactly as described. The figures do not stack up. NB insisted they are the current figures. FOR highlighted that MFT are currently the top UK recruitment site for a number of studies. Looking at recruitment numbers of 400 per annum in some cases. NB accepted that some like Add-Aspirin are more difficult to explain but all trials should be recruited to. DW asked whether it is possible to further divide those numbers into studies that have looked at metastatic disease and those in primary. NB commented that this is possible. Most of The Christie patients are metastatic. DW commented that this may be helpful for the Pfizer work discussed at the start of the meeting.
Conclusion	MA summarised that we need to improve recruitment to trials.
Actions and responsibility	**No actions.**

6. Clinical team / project updates

6.1. Radiology

Discussion summary	GH updated that QA have no facility to send out information on interval cancers and previously assessed patients who develop cancers so it's more important than normal. Normally everyone is meant to send their screening unit details of any cancers diagnosed between screens but its more crucial because the data isn't being collected elsewhere currently. GH is appealing to all the units to send a letter to their screening unit if they do have a patient. There are some symptomatic patients within the region who are very good and send the information in, yet some that are never heard from. MA commented that it is essential that any interval cancer is reported back to the screening service. GH agreed and referenced that it is a quality control issue. CG queried whether there is a representative present from all symptomatic units. GH commented that there was a lot more surgical representation at the last meeting. MA commented that there was no representation from

	Stockport. GH updated the Board on national incident feedback. Everybody has nearly been screened now that was missed before. Wigan has finished screening and have detected nine additional cancers and in Manchester so far, 23 women have been recalled. Manchester finished screening at the weekend and confirmed 10 cancers in these women. Bolton have two clinics left to screen and should be finished by the 15th September (this week). Bolton had six cancers confirmed in this cohort. There is now a new list of women in the over 72s that the screening centre are not sure are eligible for a screen or not. GH explained that there was a self-referral helpline and there has been some confusion about all the women who have referred themselves in and whether they were actually missed women or whether the publicity has encouraged them to want to be screened. There is a national panel being set up although not as quickly as initially thought, to review each case, to see whether there is any impact on the outcomes of these women. There will be a panel to make decisions so if Board members are looking after patients who are concerned, patients can be informed of the panel that will deal with those concerns. There is a complaints email address which will be shared with Board members. [RA inserted here: **Breastscreeningcomplaints@phe.gov.uk**] GH highlighted that workforce issues in radiology remain.
Actions and responsibility	**a) GH to provide complaints email address to RA for her to share/add to the minutes.**

6.2. Pathology

Discussion summary	No representation.
Actions and responsibility	**a) RA to write to MH concerning Board representation and invite MH to nominate alternative representation.**

6.3. AHP forum update

Discussion summary	VH informed the Board that the next meeting is 23rd November at MFT.
Actions and responsibility	**No actions.**

7. Transformation update

Discussion summary	MA informed the Board that he has written to RJ as promised after the last meeting. RJ was supposed to attend the Board but has been called to the Theme 3 Executive Board. There has been very little material change to the model as it stands. A paper is being drafted which if signed off by the Board will be presented to the Joint Commissioning Board (JCB) for a final decision. A decision has not yet been made. All comments have been included. MA will update the Board at the next meeting.
Actions and responsibility	**a) MA to update the Board on Transformation plans at the next Board.**

8. Bisophosphonate and Anastrazole update

Discussion summary	CH noted the need to check with local breast units whether there is a mechanism at MDT to identify eligible patients for Bisphosphonates treatment and to confirm that everyone has the email address for sending patients across. CH will send the email address to RA for the minutes to make sure everybody has it. [RA inserted below]. CG asked what the email address was for specifically. CH clarified that it should be used if there is a patient that isn't going to have chemotherapy that they get referred to the oncologist. CG highlighted the difficulties with a lack of dentists in Bolton. CH explained that if the oncologist is taking the patients on, an email needs to be sent to Nadia who is co-coordinating the service at The Christie. They still need to be seen by the oncologist, but Nadia, as the co-ordinator, needs to know via email about the referral. It needs to be co-ordinated in one place. CH updated on Astrazole. This is still work in progress. MA mentioned that he raised this to the Cancer Board, particularly with reference to patient selection. CH explained that she is working up the options appraisal. CG asked what the audit plan was. CH informed that The Christie will produce the clinical protocols and guidelines. The advice CH has received from clinicians is that if the patients are having the bisphosphonates, they will not need a DEXTA. The flow is that on completion of the sixth, the last infusion, they will notify the centralised service, they will notify the patients GP and they will notify the local breast unit that the patient originally saw. Trusts will be made aware if a patient is non-compliant. CG queried whether there is a way in which a mechanism for feedback from Nadia can be scheduled for 6/12 months' time to get some feedback about

	uptake. MA asked this to be discussed outside the meeting.
Actions and responsibility	**a) CH to send the email address to RA for the minutes to make sure everybody has it.**
	Nadia Ali - Adjuvant Bisphosphonate Pharmacist Tel: 0161 446 3443; Bleep 12144; Mobile 07824 408899 Email: nadia.ali@christie.nhs.uk Adjuvant.BisphosphonateService@christie.nhs.uk (for Christie internal queries only) chn-tr.abs.christie@nhs.net (for all l correspondence related to the Adjuvant Bisphosphonate Service from outside Christie)

9. Treatment summaries and health and wellbeing events

Discussion summary	CB highlighted that the two papers had been shared with members via RA in advance of the meeting. The SI subgroup is hoping for the Board to ratify the documents. The Board endorsed the papers. It was noted that the papers address primary breast cancer only and the title needs to be amended to reflect that. MAt referenced that a small community event took place on Friday 7th September. There was a patient suggestion to add a reference to Gateway C for GPs in the two documents. CB and FOR think this is already included in the patient friendly letter which goes to the GP and patient so already included.
Actions and responsibility	**a) CH to amend the title of the two papers (treatment summaries and health and wellbeing events) to reflect that they cover primary breast cancer only. CH to then share with RA for circulation.**

10. User involvement

Discussion summary	MAt highlighted that work is underway to scope current support groups and l what exists in the local areas. One patient has volunteered to undertake some scoping. CEG highlighted that there is a Macmillan document in existence which would be a good starting point. It was noted that a central electronic resource is required.

	VY described the poster that is being designed to enhance patient recruitment to this Board.
Actions and responsibility	**No actions.**

11. AOB

The Board were reminded to sign the signing in sheet before leaving.

MA informed Board members that Stockport is having serious problems with their two week wait. There are serious concerns about capacity and demand. GH commented that Stockport have lost a colleague and there is a lone radiologist working there. This is common across GM and very risky.

12. Close

MA thanked board members for their contributions.