Peninsula Cancer Alliance

Meeting of the Peninsula Cancer Alliance (PCA) Breast Site Specific Group (SSG)

Monday 5th March 2018 (14:00-17:00)

The Arundell Arms Hotel, Lifton, Devon

This meeting was sponsored by AstraZeneca, Chugai, Novartis, Pfizer and Roche

Chair: Charlotte Ives
Consultant Surgeon-Royal Devon and Exeter NHS Foundation Trust

1.0 **Welcome and Introductions**

1.1 Please refer to separate record of attendees.

1.2 The minutes of the previous meeting were considered and accepted as accurate.

2.0 ABS Update January 2018

2.1 Compliant across the Peninsula with MDT meetings and LWBC working party as per the Cancer Alliance transformation project.

3.0 Shared Clinical Guidelines

3.1 The group does not currently have up-to-date shared clinical guidelines for the management of patients with breast cancer within the Peninsula-this is a requirement of Peer Review.

3.2 Consideration will be given to the possibility of adopting the Breast Cancer Guidelines of the Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance (SWAG).

3.3 The constitution has been updated by NK to reflect the change from the previous Networks to the Cancer Alliance. This will be circulated for comments.

3.4 **Action**: NK to circulate the SWAG clinical guidelines and Draft PCA constitution to the group for comments prior to the next SSG meeting.

4.0 Living With and Beyond Cancer (LWBC)

4.1 **Guest Speaker: Jonathan Miller (JM)**
NHS-England: Southwest Cancer Programme Lead

4.2 With regards to LWBC, the overall expectations of the national team are;

(i) Implementation of the four elements of the *"Recovery Package"*;

- Holistic Needs Assessment "HNA"/Care Planning
- End of Treatment Summary
- Cancer Care Review
- Health and Wellbeing Events

(ii) Implementation of risk stratified pathways of care (patient follow-up/supported self-management).

4.3 In 2017 the national team asked all Cancer Alliances to bid for transformation funding to assist implementation, and to describe how all patients will be considered for risk stratified follow-up.

4.4 The target for breast cancer over the next two years is for 80% of patients to receive the recovery package and increasing numbers to be stratified to supported self-management where it is appropriate to do so.

4.5 The Peninsula has received £1.5M over the year to support this project.

4.6 SWAG Cancer Alliance has agreed stratified pathways of care for breast cancer patients (this document has been circulated to the group).

4.7 Whilst risk stratification is not a universal approach, it is important that all patients are considered either for supported self-management or continuing care.

4.8 SWAG has also agreed that for suitable patients, there will be no out-patient follow-up.

4.9 It is important for all patients to be educated as to the signs/symptoms to look out for and to have rapid re-access directly back into services should they require it.

4.10 Alliances are agreeing approaches, and for many, the transformation funding will be utilised for band 4 support workers to work alongside CNSs; funding will also be used for senior therapeutic input, health and wellbeing events and there is capital to support remote monitoring (software).

4.11 **Questions/Answers**

4.12 **Q**: *Is anyone using remote monitoring?*

4.13 **A**: Yes- the PSA tracker started in Bath, South Devon also remotely monitor their prostate patients.

4.14 It was reported that North Devon were providing remote monitoring of prostate patients but no longer do so. JM advised that this should be re-commenced and that funding is available to support this.

4.15 Remote monitoring does not have to done via a stand-alone system. There is money to develop systems via the Somerset Cancer Register (SCR) and Infoflex- the additional funding is to ensure speed of IT development and help to meet national metrics within the year; SCR are due to provide an estimated time scale for software roll out.

4.16 JM encouraged Trusts to feedback problems with practicalities of remote monitoring.

4.17 Patients need to be reassured about alternatives to clinic follow-up and to ensure that they understand how to re-access services either directly or via telephone support should the need arise.

4.18 It is important that Trusts are aware of the need to agree the point at which patients

are risk-stratified to supported self-management, and what is required to achieve this.

4.19 Torbay has undertaken risk stratification for some time, and hope to run nurse led follow-up clinics in the future. It is thought that most patients at Torbay will go on to a supported self-management follow-up pathway.

4.20 Some clinicians are still undertaking a 5 year patient follow-up; this is not necessary for all patients and teams need to think carefully about what the patient needs are and what is in their best interests. For example in some trusts prostate patients are referred on to a PSA tracker for onward care. The tracker is managed by a CNS and yearly HNAs are offered. On the basis of patient experience, this is better for them and there is an expectation from the National Team that patients seen in clinic for follow-up will decrease appropriately.

4.21 **Guest Speaker-Maria Bracey** (CNS/LWBC Lead RDE)

4.22 LWBC has been active in Exeter since 2016.

4.23 HNAs are carried out electronically (via iPads) and since April 2017 a common denominator has been used to determine baseline working;

4.24 Breast Care Nurses have recorded 248 eHNAs since April 2017, of these 238 have care plans attached to them; 207 had written care plans, 20 did not need a care plan and 11 patients declined an eHNA. A further 10 episodes of care for that period were incomplete.

4.25 There has been a lot of positive feedback for eHNAs which are now active across 8 cancer sites at the RDE.

4.26 Within the Peninsula bid for transformation funding to support attainment of the LWBC metrics, the aim was set for patients to be offered an eHNA within 31 days of diagnosis and again at 6 weeks post treatment.

4.27 Exeter has adopted a different approach to health and wellbeing clinics/events (H&W). These are offered closer to diagnosis on the basis of patient preference.

4.28 There is a generic clinic (which breast cancer patients attend), and since October 2017 outreach clinics have been made available once a month in Tiverton. Haematology has their own site specific clinic as do prostate patients undergoing RALP. It is proposed that there will be a site specific clinic for skin cancer patients in or around May 2018.

4.29 An End of Treatment Summary template has been agreed with MacMillan GPs and work has commenced with the breast team for this requirement. Feedback from patients indicates that EOTs are very popular and give clarity to the patient as to their journey.

4.30 Remote monitoring has been carried out successfully for prostate patients, currently 2,000 patients in Exeter are monitored this way.

5.0 **Breast Cancer Pathways at Torbay Hospital-**presented by Jacqui Rees-Lees

6.0 **Bisphosphonates**-presented by Matthew Rowland

7.0 **DIEP service**-presented by Rachel Tillett

8.0 **AOB**

8.1 The breast cancer nurses are happy to continue with their separate meeting prior the Breast SSG and realise the benefits that this meeting brings.

8.2 The familial breast cancer group have agreed to hold a separate meeting annually, and combine with the main Breast SSG every other meeting.

8.3 Requests for the next meeting:

(i) Commissioning update (STP level).

(ii) Metastatic nurse update.

8.4 The next Breast SSG meeting will be held on **Monday 24th September** (PM). Further details to be provided nearer the time.