Peninsula Cancer Alliance

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

13th September 2017; 14:00-17:00

Lifton Farm Shop (Strawberry Fields Conference Room), Lifton, PL16 0DE

FREEDOM OF INFORMATION

This group will observe the requirements of the Freedom of Information Act (2000) which allows a general right of access to recorded information including minutes of meetings, subject to specific exemptions. No one present today had any objections to their names being distributed in the minutes.

Draft Notes (to be agreed at the next SSG meeting)

Reference

1.0 Welcome and Introductions.

Please refer to separate list of attendees/apologies here.

2.0 **Maximising MDT Effectiveness-CRUK:** A summary of findings presented by Nina Kamalarajan (NK)

2.1. [Presentation slides can be accessed via this link].

2.2 Group discussion: it was noted that cases that take time to discuss are often breast screening cases; it was suggested that such cases do not necessarily need to be discussed at MDT, and that there could possibly be 2 classifications: those requiring MDT and those that do not require MDT.

2.3 It was highlighted that it is a requirement of the breast screening programme to discuss patients at MDT-however; there are cases where the input of a pathologist may be required, not a breast care surgeon.

2.4 It was also the experience of some group members that complex patients who do require MDT input are often left until the end of the MDT.

2.5 MDT discussion of Morbidity and Mortality (M&M) was also raised; it was suggested that quarterly meetings to look at M&M and operational issues may be helpful. However, it was noted that such meetings were challenging for some trusts to accommodate due to a lack of space for holding additional meetings.

2.6 The idea of pre-MDT triaging was thought to be helpful, and could result in

some cases bypassing MDT altogether.

2.7 It was raised as to whether or not MDTs discussed the availability of research studies for each patient at every MDT. Cornwall noted that they have a research nurse who attends their MDT.

2.8 Clinicians explained that it can be difficult to remember the inclusion/exclusion criteria for studies and that there are no prompts available on the Somerset Cancer Register (SCR) to remind clinicians to discuss the possibility/suitability of trials.

2.9 On the basis that treatment decisions often arise from genetic results, the requirement of a Geneticist to attend MDT meetings was raised. Members of familial breast cancer group explained that this issue had been raised at their earlier meeting.

2.10 The following questions were considered:

(i) How can an appropriate query for an MDT be generated?
(ii) Geneticist presence may not be required if there was clarity on the type of patient they would want to see.
(iii) Would a genetics query list on the MDT proforma be helpful?

2.11 It was noted that breast surgeons do use the proforma which includes a section on family history, however, for example, input may be required for patients considering neo-adjuvant chemotherapy.

2.12 Information about the new proforma for referral to the Peninsula Cancer Clinical Genetic service was shared with the group.

2.13 Examples of good practice were shared, and the group thought that it would be beneficial to invite Richard Beresford to the next SSG meeting as he has led streamlining work for MDTs in Plymouth.

Actions

2.14 NK to liaise with Duncan Wheatley to ascertain if there are any software opportunities that would allow trial prompts to be raised at MDTs.

2.15 NK to invite Richard Beresford to present at the next SSG meeting to talk about MDT effectiveness.

3.0 **Patients Pathways**

The group were invited to share their experiences/thoughts on patient

pathways across the Peninsula:

3.1 **South Devon and Torbay NHS Foundation Trust (TSD)**

The diagnostic and treatment pathways remain unchanged, but moving forward patients will be seen at 3 months following radiotherapy and if oncology is happy with the treatment then the patient will be discharged from oncology (or seen again if required). Once discharged, patients are referred to see a surgeon or a nurse where a health needs assessment (HNA) is carried out, and a treatment review undertaken. It was estimated that 70-80% of patients would be discharged at this stage.

3.2 Virtual clinics at planned intervals are also being considered as are other patient tracking ideas. RCH are also streamlining how patients re-access services and guidelines to assist this are in progress.

3.3 **Royal Devon and Exeter NHS Foundation Trust (RDE)**

The RDE currently follow up their patients for 5 years post treatment with no system in place as of yet for streamlining/stratifying follow-up. It is hoped that a similar system to TSD will be procured.

3.4 **Royal Cornwall Hospitals NHS Trust (RCH)**

RCH has a new endocrine clinic run by breast care nurses and there is a move towards decreasing routine follow-up. Endocrine patients are seen once a year and are compliant with this.

3.5 Radiology follow up is straight forward and the RCH have a walk-in follow up programme whereby patients are invited to attend at any time in the month of August between 9-5 for mammograms on an ad-hoc basis and this is working well.

3.6 Follow up for patients who have had breast reconstruction follow a different pathway; it was noted that psychological needs can be managed at a distance., however it should be the consultant's decision as to who is discharged as some patients may not be ready.

3.7 It was suggested that re-access to services for prostate patients is done really well and needs to be improved for breast patients.

3.8 **Actions**:

NK to invite Mike Green to present his pathway work at the next SSG meeting.

4.0 **Research Update Presented by Duncan Wheatley (DW)**

Research update available here.

4.1 Group Discussion:

The group discussed about how Trusts recruit to trials and whether it was a possibility to add on boxes to the SCR to facilitate reminders to discuss at MDT.

4.2 It was acknowledged that research nurses help to recruit to trials, but not all trusts may have the relevant support.

It was suggested that improved collaboration across the PCA may make it easier to identify relevant patients to recruit to trials.

Action:

4.3 NK to liaise with DW and Julie Cunningham to discuss strategies to improve recruitment across the Peninsula.

5.0 **Quality Indicators/Data Collection**

Group discussion about practice across the Peninsula:

5.1 RCH undertake normal external audits, and presence at ABS, RDE do similar.

5.2 RCH also present data on an annual basis on BREAST-Q regarding involvement and decision making. M&M data is collected quarterly. It was noted that the progress of older patients with breast cancer and frailty/co-morbidities are not fully known, and whether or not it would be beneficial to link with care of the elderly teams?

5.3 RDE hold M&M meeting most months. Free-flap surgery outcomes have been looked at, and following audits, changes have been made. RDE are also undergoing a continuous cycle of audit related to surgical site infections.

5.4 HNAs are carried out on ipads donated by FORCE.

5.5 TSD use info-flex to track patients and pick up surgical site infections which are then escalated to the nursing team

5.6 It was felt that similar data is being collected across the Peninsula Trusts.

6.0 **Living With and Beyond Cancer (LWBC)**

RCH undertake HNAs prior to surgery and 6 months after this is working well. There are no plans for end of treatment summaries yet.

6.1 PHT-all elements of the recovery package are in place, HNAs are being undertaken for 75% of patients and end of treatment summaries are also being carried out.

7.0 **AOB**

Mr Sheikh Ahmad notified the group that he will step down as Breast SSG Chair.

7.1 **Action**:

NK to email group for nominations; nominees will need to be seconded by at least one member of the Breast SSG.

8.0 **Date of Next Meeting**

TBC

Action:

NK to send out possible dates for the group to vote on, taking into account that many SSG members from TSD were unable to attend the meeting today due to their MDT being held on a Wednesday.

Breast SSG Summary of Actions

Reference	Subject Matter	Summary	Action
2.8 and 2.14	Research	There are no prompts on SCR to remind clinicians of trials that may be suitable for their patients.	NK to liaise with Duncan Wheatley to ascertain if there are any software opportunities that would allow trial prompts to be raised at MDTs.
2.15	Sharing Practice	Optimising MDT effectiveness	NK to invite Richard Beresford to speak at the next meeting.
3.1 and 3.8	Streamlining Patient Pathways/Risk Stratification	Sharing practice	NK to invite Mike Green to present his pathway work at the next SSG meeting.
4.0 and 4.3	Research	Recruitment to trials across the Peninsula is sub-optimal.	NK to liaise with Duncan Wheatley and Julie Cunningham to discuss strategies to improve recruitment across the Peninsula.
7.0 and 7.1	Breast SSG Issues	The group require a new chair person.	NK to email the group regarding nominations for chair.