



Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Services

Meeting of the SWAG Network Breast Cancer Clinical Advisory Group (CAG)

Tuesday 20th September 2022, 13:00-16:00

Engineers' House, The Promenade, Clifton Down, Bristol, BS8 3NB and MS Teams

Chair: Professor Mark Beresford (MB)

NOTES

ACTIONS

(To be agreed at the next CAG Meeting)

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the SWAG website [here](#).

2. Review of Previous Meeting Report

As there were no comments or additions to be made to the report from the previous meeting on Friday 18th March 2022, the report was accepted.

Actions from the last meeting are on the agenda of the meeting today.

It was beneficial to have the opportunity for a hybrid event and to see regional colleagues face to face for the first time since March 2020.

3. Clinical Guidelines

Please see the presentation uploaded to the SWAG website

Presented by M Beresford

Given the number of new treatments emerging for breast cancer, collaborative work on network guidelines will be undertaken and ratified by CAG. This will increase efficiency and avoid duplication of work in individual centres.

3.1 Extended use of Oncotype-DX

As previously discussed, the Oncotype-DX genomic test, used to predict the benefit of chemotherapy or not in early breast cancer, is currently NICE approved and routinely used in node-negative oestrogen receptive positive disease. However, there is evidence from the RxPONDER trial that shows node positive patients (in particular for those who are post-menopausal) with a low or intermediate score have very little benefit from chemotherapy, making the test important to help guide decision making in this patient group.

With this in mind, CAG have used the test in the node-positive patients since the start of the COVID-19 pandemic, with funding agreed by the SWAG Cancer Alliance. This has reduced the number of patients receiving chemotherapy as the majority of results come back as low to intermediate risk.

It is more pertinent than ever to continue to use the test due to current workload pressures.

Recommendation: Breast CAG advise that extended use of the Oncotype-DX test continues across the region for the node positive low to intermediate risk patient group.

**CAG
Recommendation**

There is usually some debate at the MDT meetings as to whether funding of the test is still agreed, but the oncologists will continue to request the test as no-one has informed Breast CAG to stop doing so. The Cancer Alliance has been contacted for updates but due to a recent change in leadership this was chased again prior to the meeting today.

It could mean that a higher risk group of patients are recruited to OPTIMA, but it is probable that there was a skew towards recruiting lower risk patients at the outset of the trial.

Attempts have been made to find contacts within the Trusts to invoice the Cancer Alliance for the tests but none have been submitted to date.

The delayed approval by NICE is perhaps due to a lack of evidence in survival benefit; it would be helpful if NICE measured the capacity benefit that the test provides.

Somerset FT have submitted an Expression of Interest in the PRE-DX trial which will assess the earlier impact of genomic testing in the treatment of breast cancer and allows access to free tests. It is hoped to open as soon as possible and will remain open to recruitment until April 2023.

Action: Chief Investigator H Cain to be contacted by M Beresford / others to discuss PRE-DX further.

**M
Beresford/Interested
PIs**

3.2 Extended Endocrine Therapy

A letter has been drafted in response to GP queries on continued hormone therapy 5 years after diagnosis and is presented to see if the information can be standardised across the region.

In RUH, the system Cinapsis has been purchased which enables GPs to contact teams for advice and guidance; the letter has been uploaded to this system to help manage the volume of queries.

The guidance, which is within the presentation, needs to be updated frequently as it is a constantly evolving field. It is quite complicated and is anticipated to generate queries.

Action: The letter will be shared for review by CAG and may be reworded.

H Dunderdale

Patient Representative J Chambers reported that patients experience a lot of fear and confusion around changes to the adjuvant treatment schedules and it is vital that clear information is communicated.

The letter is copied to the patient and should then be discussed with their GP but sharing it further in patient forums will be explored.

Action: To research patient forums available for information sharing

H Dunderdale

Macmillan GP and BNSSG ICS representative G Beard anticipate that the letter will be complex for GPs to interpret given that outcomes vary for each patient.

It is not clear if the guidance is stopping referrals back to clinic for an endocrine review; some patients were being referred via the menopause service or alternative routes. It used to be possible to bring patients back for a 5 year review; there currently isn't capacity to achieve this.

An aspiration for the group would be to provide 5 year reviews, especially as many more adjuvant treatments are anticipated in the near future.

Action: To develop a role dedicated to endocrine treatment reviews, which could potentially be undertaken by a Clinical Nurse Specialist or Pharmacist; to escalate to the Cancer Alliance / Workforce Strategy Project Team to see if there would be funding to support this.

H Dunderdale

It could be incorporated into the risk stratified pathway and supported via the patient portal / remote monitoring system once this is made available.

3.3 Abemaciclib implementation plans

Another significant change since the previous meeting is the approval of adjuvant Abemaciclib CDK4/6 inhibitor. For some time, the treatment has been available for those with metastatic disease, but can now also be given to high risk hormone positive patients who have had lymph node involvement, may have had chemotherapy, and who would normally be discharged with long term endocrine treatment.

It is approved for two years and dispensed through the hospital.

Patients are seen monthly for blood tests and toxicity checks.

The most common toxicity is diarrhoea which can be quite severe for the first few months.

Additional resources will be required as this cohort of patients would normally be discharged but will now undergo treatment for a further two years. It will also have an impact on patients in terms of increased hospital visits, GPs with additional blood tests, and on pharmacy. The drug also costs approximately £3,000 per month.

The impact on oncology services in RUH has been assessed, which shows an additional 6 clinic appointments will be required every week. This is the equivalent of a pharmacy prescriber clinic and RUH are in the process of training a pharmacist to run the clinic, but no funding had been secured to provide cover for the time this would take out of the pharmacy.

Other centres in the UK have said that they will not offer the treatment until additional resources have been put in place.

In UHBW, it is being offered to patients with no plan for additional resources. Two ANPs are taking on the work, raising concerns about workloads which are already full.

The impact of new treatments needs to be prospectively quantified to provide evidence of the additional resources required. For example, when a new heart

failure drug was approved for cardiology, they made the case that an additional Consultant, 2 nurses and clinic room would be required before this could be prescribed.

Five new drugs have been approved in the last few months with more on the way. Scoping the associated workload for each of these is going to be a huge piece of work.

CAG could collaboratively raise the impact of new drugs on service capacity to Trust Management Teams and share this workload across the network rather than work on local solutions.

It is anticipated that there will be further expansion of the Clinical Oncology and Medical Oncology posts in the South West and evidence from these scoping exercises could be used to bid for the 50% of funding that will be available for these training posts. The problem will be finding the other 50%.

Somerset FT are also offering Abemaciclib to patients, with three appointments about this in the last two weeks, but are currently short of two Breast Oncology Consultants with no planned recruits in sight due to the national shortage. At present it is unclear how the extra workload will be managed.

It was not considered necessary for all centres to repeat the exercise undertaken in RUH to assess the impact of Abemaciclib as this can be shared and extrapolated; it took around 12 hours of meetings over 6 months to complete.

Work is underway in other parts of the country to assess the number of metastatic patients on long term treatment, currently in the system, so that the magnitude of this ever-increasing population can be recognised by funding bodies.

A recent survey of junior colleagues showed a worrying lack of enthusiasm in breast cancer roles, with two out of forty expressing an interest. This may be due to the Royal College of Radiotherapy curriculum and has been raised as an area of concern.

Use of the CDK4/6 inhibitors Palbociclib and Ribociclib in the metastatic setting may switch, although Palbociclib was noted to be very well tolerated and the trial data on the two was not directly comparable.

Now that the trial data had matured, it appeared that Palbociclib did not show an overall survival benefit in comparison to Ribociclib; there were uncertainties around this given that progression free survival was identical.

Ribociclib requires ECGs which causes some logistical problems and may not be as well tolerated; regional colleagues are still considering whether to make the change.

The Serena 6 trial does not accept patients on Ribociclib and there are currently no plans to change the protocol.

Drug representatives for Ribociclib have arranged for Healthcare At Home to take ECGs and blood tests in the community to try and make it the preferential treatment; the switch will be considered further.

4. Research

4.1 NIHR Clinical Trials update

Presented by C Matthews

Please see the presentation uploaded to the SWAG website.

National recruitment to breast cancer studies shows that 23,312 patients were recruited to 150 trials during April 2021 to March 2022. For the current financial year to September 2022, 8,857 patients have been recruited to date. The majority are non-commercial interventional.

Regional recruitment has surged, with the West of England (it was not possible on this occasion to include the figures from Taunton and Yeovil) being now the fourth highest recruiter in England, which is particularly impressive given the size of the network in comparison to others.

The presentation contains a list of six trials where the Chief Investigator is within the region. The full list of open studies (which will be populated by nominated members of the research teams) and trials in set up will be circulated.

CAG are asked to check the list for any missing trials and feed back the most helpful details to add to the template that is being developed for the purpose of improving cross-referrals.

Action: Circulation of all Breast Cancer Studies open in the SWAG region; members to comment on studies available locally

H Dunderdale/CAG members

Consultant Oncologist R Bowen creates the lists for the Gynae CAG which works really well as it provides regular updates of what is open and where. It also includes trials outside the region.

General update from the NIHR:

To increase capacity and revitalise the research portfolio, the CRN are helping to facilitate the Department of Health and Social Care (DHSC) to identify studies that need to be closed as no longer able to complete as planned since the pandemic. This is called the Research Reset Initiative; PIs may be contacted about this and are encouraged to contact C Matthews if any help is required.

In 2024, the CRNs contract with the DHSC will end and the CRN will be rebranded as the Research Delivery Network to reflect the expansion into Social Care and non-NHS settings.

The geography of the West of England network is expanding to include Dorset and Salisbury to match more closely with the ICB region. Unfortunately this will still not match the geography of SWAG.

The Trust hosting the CRN may also change from UHBW, but this is currently unclear.

Useful NIHR website links are included in the presentation available on the SWAG website. CRN team details are also included for members to contact with any queries.

There is a large list of trials open in Somerset that are not listed in the presentation to which the team would welcome cross-referrals. There are two new adjuvant

trials and FNS in the metastatic setting. These are thought to be on the full list that will be circulated.

Ideally Somerset FT and Yeovil should be included in the West of England CRN to ensure optimal access to trials.

C Matthews works with regional colleagues to gather data from all relevant centres. This is sometimes challenging due to research being recorded on different information systems.

5. Coordination of patient referral pathways

5.1 Breast Faster Diagnostic Pathway Guidance

Presented by H Dunderdale, CAG Manager/J Chambers, Patient Representative

NHS England have produced a document 'Faster Diagnostic Pathways: 'Implementing a Timed Breast Cancer Diagnostic Pathway' document which was circulated prior to the meeting.

While it had not been possible to arrange for the clinical team who produced the document to attend today, Patient Representative J Chambers is part of the national board task and finish group.

The national team have sent Breast CAG the following information:

NHS England have committed to establishing a dedicated Breast Pain pathway and are following the East Midlands model which has been positively evaluated. They are working towards enhanced clinical triage and establishing the associated service models that are required to take demand off triple assessment clinics and therefore ensure that those who need imaging/biopsy get this in the shortest time possible.

The team is reviewing workforce and has funded some alternative workforce models, such as Physician Associates, to contribute to front end activity so that Consultant Surgeons can be released to operate.

We feel it's important to get these things right before progressing with wider pathway improvement.

NHS England ask Breast CAG if Breast Pain Pathways or robust clinical triage of referrals are currently in place.

It is understood that Consultant Breast Surgeon C Osborne has put in place a new clinical triage system in YDH and will provide a presentation at the next meeting.

Patient Representative J Chambers' experience of the task and finish group was that the proposed pathway very much followed what was already in place.

One key point to note is that the definition of diagnosis now includes all receptor types except for FISH as pathology has said this would be impossible to achieve by the 28 day faster diagnostic standard.

NHS England are due to start measuring Trusts' performance on each stage of the timed pathway in order to identify the pressure points, which is likely to be

Radiology and Pathology, but they are of no other consequence, with the 28 day target being the only one included in Cancer Waiting Time Performance targets.

The pathway is split into three sections:

- Cancer Suspected: As per the current two week wait pathway
- Cancer Not Suspected: This is where the Breast Pain Pathway sits and aims to standardise breast pain management across the country
- Screening pathway: This defines the route back in and the clock start and stop points.

From a patient perspective one of the most crucial things is getting timely information. There is currently a perception with the two week wait pathway that not being seen within two weeks will have a detrimental impact on survival outcomes, so it is important to reassure patients that this is not the case when managing patients outside this time frame.

Information should be shared via multiple routes such as digitally as well as using leaflets.

GPs also need to be informed of the diagnosis as soon as possible.

Discussion:

Across the South West, Breast Cancer Services are currently failing to meet the 62 day Cancer Waiting Time (CWT) target. This is due to delays in the earlier part of the pathway with radiology and pathology limitations and the long-term growth in demand with services consistently working at maximum capacity.

Long-term planning is required to address this, in particular by looking at supporting the workforce. When one-stop clinics are fully resourced, services run smoothly, but there is no extra give in the systems to manage surges in referrals (demonstrated after breast cancer awareness campaigns) or workforce sickness.

The NBT two week wait position is currently very challenged. Historically, this was due to shortages in radiology workforce, but at present there is a shortage of surgeons, with several retirements occurring at the same time and a delay in replacements coming into post.

There have been recent improvements to the radiology workforce with several more radiologists being recruited and recent training of two consultant radiographers. One vacancy remains unfilled.

It was noted that it would take only one glitch in workforce provision to have a detrimental effect when a service is only just managing such a high-volume workload, then catching back up is doubly hard.

Sickness due to COVID has led to longer staff absences so there has been no spare capacity to recover CWT targets.

It is the high volume of breast cancer referrals which makes it the focus of Trust level performance as, if the Two Week Wait CWT fails for Breast, the Trust will fail for Two Week Wait, and likewise for 28 and 62 days.

There is currently a 45 day wait for a first appointment in NBT.

There is an increasing number of patients that have self-referred to the private sector, can't really afford it, and then end up sitting between the two systems which has a negative impact on the patient experience.

Patient Representative J Chambers recommends managing patient anxiety while waiting for their appointments to alleviate fears that are often escalated by the media, by removing any information about being seen within two weeks and providing the realistic time frame and reassurance that this won't affect their outcomes.

Action: Cancer Alliance Clinical Director, H Winter asks that Breast CAG highlight any requirements / solutions to the Cancer Alliance to help improve the pathway as there are opportunities to upskill roles at present.

Breast CAG members

Examples may include upskilling colleagues to help manage the workload of the interventional radiologists / other colleagues taking biopsies and increasing the number of people able to perform physical examinations and development of advanced roles.

6. Clinical opinion on network issues

6.1 Service Developments

Presented by C Griffiths and N Smith

Please see the presentation uploaded to the SWAG website.

RUH Divisional Manager for Breast Services, C Griffiths, and NBT Deputy Chief Officer for Cancer Services, N Smith are working collaboratively across both Trusts to identify potential service improvements in recognition that the pressures on services are not just local but ones that have been shared regionally and nationally over a long period of time.

There are currently 400 vacancies (1 in 10 posts) for Consultant Radiologists with the Breast Radiologists being the most in demand; 25% of units lack at least one radiologist and retirements are expected to overtake new recruits in the next decade.

There is a lot of national focus on general radiology, for example manning diagnostic hubs, and not enough focus on breast imaging specialists in comparison to other areas.

Summary of main issues:

- Inequality in access across different hospitals locally
- Variation in performance targets
- Workforce shortages / crisis
- Reliance on high cost locums and/or insourcing
- Demand outstripping capacity – growth in worried well.

Although there are opportunities to invest in workforce at present, the people are just not available, so an alternative type of workforce model is required.

NBT is part of a national Tier system process which means that there is money available to make change, although this is often non-recurrent.

Reliance on high cost locums needs to be reduced. They are not embedded in Trust processes and this often creates additional work for clinical teams.

The group was asked if some of the issues could be addressed by the introduction of a breast pain pathway and if the shortfall in radiology can be addressed with a collaborative SWAG radiology training programme.

Service demands are currently limiting the ability to train at the scale required.

Manchester Foundation Trust Charity 'Build to Beat Breast Cancer' appeal are campaigning to raise £3.5 million to build a national breast imaging training academy to tackle the shortage in Radiologists, and it may be that a similar plan could be implemented in the South West.

Discussion:

Collaboration with the Manchester team was recommended.

Action: C Griffiths to liaise with Manchester Foundation Trust Charity and see if it may be possible to expand this to include a Bristol based training academy

C Griffiths, N Smith

SFT Associate Breast Clinician Z Goldthorpe is President of the Association of Breast Clinicians and is aware of Breast ~~Cancer~~ Clinicians that are already engaged in this programme in the SWAG region.

[Health Education England \(HEE\) funding is filtered through the National Breast Imaging Academy \(NIBA\), to fund the Breast Clinician Credential pilot project run by the RCR / ABC and HEE. This commenced in 2019 with 10 posts offered at that point, some of whom were in the SW region. Doctors began in post between 2019 and early 2020, some on a LTFT basis. Funding was released by HEE providing trusts with £30K per annum for three years to assist with training and salary. A second cohort of 10 trainees was launched in 2021 with appointments commencing late 2021 / during 2022, again some full time over 3 years, some LTFT.](#)

The funding was for a pilot scheme from HEE. This has now ceased but trusts can still appoint Breast Clinicians to train through the credential scheme but will be responsible for all salaries and on costs.

Further funding from cancer alliances within the region, could be used for training these doctors if the cancer alliances think it is a good use of funds. Eventually the board believes these posts will be funded by ICBs. Independent economic analysis of the pilot scheme has shown the project to be efficient and fantastic 'value for money' / return on investment.

The programme board continues to work with all screening centres and symptomatic unit to promote uptake of the Credential scheme in the ongoing workforce crisis. The programme board and ultimately the RCR oversees accreditation and validation of these doctors.

Yeovil could provide some support with training in symptomatic imaging and clinical skills. The screening side of things would need to be provided by SFT (given impending merger). A business case from YDH / SFT would need to be constructed to assess the need for another BC (currently one in year 1 of training) in Somerset, two other established full time BCs in Taunton. This may be a good strategic move but some considerable additional background work needs to be completed before this is feasible.

Recruitment to these posts has been tricky in some units nationally. The most robust and effective appointments have been with someone who is settled in the region, wanting to stay in the region, transferring from another training programme or GP, word of mouth is a powerful tool finding the right fit.

~~The National Breast Imaging Academy (NBIA) based in Greater Manchester provides funding via Health Education England and have done this for an additional 20 Breast Cancer Clinicians this year.~~

~~The South West region is one of the largest recruiters of Breast Cancer Clinicians, with trainees now in post in RUH, NBT and Somerset FT and soon to be in post in Truro and Gloucestershire.~~

~~There is no more funding available at present for the posts.~~

Action: To discuss access to funding Breast Clinician Posts with the Cancer Alliance.

Buy-in for the curriculum to be developed further into a recognised training scheme is now required so that units can take on these Breast Cancer Imaging Specialists who are also trained in family history and other clinical skills, providing workforce flexibility within the team.

H Dunderdale

Training is undertaken over three years full time with Manchester overseeing the outputs.

The majority of centres are at saturation point for capacity to manage trainees at present.

The two Consultant Radiographers in YDH would be willing to provide support with training.

Action: To contact YDH Consultant Radiographers to arrange training posts

One big issue is the rising demand of worried well referrals, not all of which require imaging. Provision of a breast pain service, co-designed with Primary Care and based in the community may reduce the burden on acute providers.

There are concerns about how a community service could work at present due to the quality of the referrer and referrals currently being received. Patients are being referred by people with very little training in clinical assessments of breasts, such as Practice Nurses and Paramedic Practitioners who are not confident to assess if there is a lump or not and so refer the patient in as a precaution.

It could be possible to mitigate this by providing training to individuals who have been identified to run a regional breast pain pathway, with the Secondary Care team producing the detailed criteria for breast pain versus acute referral. Funding could be sourced for this to be provided as a region; it would probably take a few years to implement.

GP representative G Beard confirmed that there is a breast pain pathway in BNSSG which differs from the East Midland model.

In BNSSG, there are less GPs than there are hospital consultants and so there are changes underway to adapt workforce, but everyone should be working within their clinical competency.

It was recommended that it was preferable to work on the training needs of the individuals making the referrals rather than creating a new pathway.

The majority of breast pain is managed in Primary Care by GPs. There are excellent resources already available to help with clinical decision making on this.

Creating a breast pain pathway may result in GPs referring patients on rather than continuing to provide the existing level of care.

Once patients are referred via the two week wait pathway, the majority get imaging for which there is now a 12 week wait.

NBT are trialling a breast pain pathway where over-40s are sent to mammogram, when imaging may not be required. However, patients with persistent unilateral breast pain will not be reassured without imaging.

Demand is growing at a pace that services cannot meet. A cross-provider group of clinicians is needed to agree standardised criteria and resourcing for a regional pathway.

Breast CAG Imaging Specialists

The same support is required that was provided for the Prostate Cancer Working Group in terms of Project Management support. A formal request will be put forward to the Cancer Alliance Delivery Group.

Action: C Griffith and N Smith to discuss a project proposal with L Brown

7. Patient Experience

7.1 The Big Impact of Brief Encounters

Presented by Patient Representative J Chambers

Please see the presentation uploaded to the SWAG website

C Griffiths/N Smith

National and Regional Patient Representative J Chambers gave an introductory summary of her experience as a breast cancer patient and explained that undertaking the role of Patient Representative was, although there is always room for improvement, motivated mostly by her experiences of good care.

The things that make a difference between good care and not so good are often very small and, given the current pressures on services, it was timely to emphasize the impact that a personal approach can have on patients' lives.

Sometimes the actual thought of taking medicine for controlling your metastatic disease can be nearly impossible to tolerate due to anticipation of the side effects and living with cancer is incredibly scary; what helps is the holistic care and support given by the patient's medical team.

Examples include:

- A nurse remembering her preferred name
- Fitting cancer around other life priorities: the surgeon flexing her operation date to fit around a scheduled exam / remembering details about her personal life (the surgeon made a habit of noting such things after clinic appointments) which helps to build trust
- Asking how someone how they are really feeling: At a low point, her surgeon gave her the time to talk through her feelings, despite being in the middle of a busy clinic, which helped her access much needed support. This had also happened with her oncologist during a telephone call recently, which was reassuring and was passed on to her CNS
- Explaining exactly what is going to happen: Having a neck biopsy when you must lie completely still and have the needle inserted is very challenging; this was helped by the radiologist talking through exactly how the biopsy would be undertaken, giving confidence to consent to the procedure
- Control: Rearranging a blood test to allow for a whole week holiday and being given choice over how contact will be made. A receptionist recently called to update that telephone clinics were running an hour behind, preventing distress waiting for the call
- Continuity of care wherever possible: This allows continuation of conversations, of monitoring progress and side effects and significantly improves the patient experience.

There is not enough time to go through all of the examples of the help that has been provided by the CNS team, who give you their time, don't pass judgement,

are not phased by anything, and coordinate everything with the rest of the multi-disciplinary team.

Discussion:

Breast CAG were grateful for this helpful and positive feedback.

There were numerous useful points to pull out, including getting the balance right with face to face and virtual appointments and trying to arrange for continuity of care.

It used to be possible to write reminders about personalised information in patient notes, but now notes are electronic, another method of recording this will be explored as this sets appointments off on the right foot.

7.2 Holistic Needs Assessment (HNA) Data

Presented by H Dunderdale

Please see the presentation uploaded to the SWAG website.

It is hoped to look at outputs from HNAs in CAG meetings to help make recommendations for patient experience improvements. It has been challenging to access this but now Personalised Care and Support Project Manager, H Shallcross, has gained permission from the majority of SWAG Trusts to have access to Macmillan eHNA data.

The data extracted relates to activity in August 2022 and excludes RUH and Somerset FT as they are not using the eHNA system at present.

Although eHNA data will not currently correlate with what is happening in each organisation, there are some valuable things that can be sourced from it and it is possible to look at how HNAs are being recorded on the COSD website. In particular, RUH are consistently recording HNA activity via this route.

Information sourced from the eHNA data:

- Number of assessments done by tumour site (inaccurate at present)
- Who completes the HNAs (this varies between Clinical Nurse Specialists and Cancer Support Workers)
- The stage in the pathway where the HNA was completed
- Where it was done - by telephone or face to face
- Average duration - approximately 6 minutes
- Rate that concerns are raised – top three:
 - Worry, fear or anxiety
 - Thinking about the future
 - Sadness or depression
- Actions taken to address concerns – the majority of which involved signposting patients to Macmillan online resources.

CAG are asked if HNA outputs should be regularly analysed – it will be possible to download monthly from now on and so will increasingly build a body of evidence of the priorities for your patients and, given the top three concerns, if the group recommends increased access to Psychological Level 2 training opportunities.

Lead Cancer Nurse B Ockrim has compared the data with the HNA activity recorded on a new dashboard for both YDH and SFT.

Previously it wasn't possible to see if HNAs were achieving the 80% target, but it is now possible to see that this was being offered across all sites. Overall patient contacts were 15,000 in the year to date with 1400 HNAs being completed.

Eventually the dashboard will include other Personalised Care and Support activities such as provision of Health and Wellbeing events and care plans.

On looking at the length of time it takes for individuals to complete HNA, which is between 30-60 minutes, it would seem that the data from eHNA is incorrect and probably refers to the time it takes to enter the data on that system rather than the length of the actual HNA clinic appointment.

The majority are completed within three months of diagnosis. The dashboard has a tracker so the teams can see if any newly diagnosed patients have an outstanding HNA.

HNA completion is going to move to eHNA in the near future, so data will increasingly be available via that route.

Completion of HNA has informed significant changes in information requirements in terms of streamlining what is given and when. For example, it is important that an HNA is repeated at around cycle 2 of SACT and at other key points as tailored to the individual rather than at the beginning and end as instructed by NHS E. Recurrent or metastatic diagnoses should be treated as new cases to pick up all changing priorities.

Top priorities overall have changed over the past few years, with psychological support now listed in the top three, as is financial support.

It is unfortunate that, when discussing treatment options, patients are often having to consider what they can afford to do, rather than what is the best treatment option.

When everyone has moved to the eHNA system, it will be really useful to home in on priorities, which may be site specific or specific to individual Trusts.

It was agreed that extra psychological support was a priority as there was a shortage of psychologists and counsellors across SWAG, and many people who had previously undertaken Psychology Level 2 training required these skills to be refreshed.

It would be useful to collate evidence on the benefit that HNAs provide. This is being gathered and is proven to support patient care and drive change.

Macmillan looks closely at the actions of those issues scored between 6 to 10 to ensure that the information given is of lasting benefit and the time taken to complete HNAs is optimised.

It is important that the information is converted into a care plan that can be shared; it is unclear if this step is happening / if all members of the clinical team know how to access this information. It is possible to share with GPs if Secondary Care add the GP practice to the eHNA portal. Work is underway with the Primary Care Network to optimise information sharing so when GPs complete Cancer Care Reviews at 3 and 12 months this information is available to make a more rounded assessment.

HNA outcomes will be reviewed at a future meeting when more information is available.

Action: Potential agenda item for future CAG meeting – HNA outcomes

8. Quality Indicators, Audits and Data Collection

8.1 Management of the Axilla

The table that has previously been circulated and ratified is in line with ABS Guidelines; action closed.

8.2 Breast Cancer Pressures National Group

Please see the presentation uploaded to the SWAG website.

A national project is underway to look at the number of patients in the system receiving ongoing treatment with metastatic disease to get a clearer steer on how to manage the workload. The project team have requested a number of data points to facilitate this, which looks like a lot of work to collect.

This will hopefully help inform the need for increased service provision.

Local data on the number of SACT treatments recorded each month over the last year shows a slow trend up, which is the same in all centres; this is powerful information to back up what is felt to be happening on the ground.

8.3 Any other business / format of next meeting

The 2023 meetings will convene in a similar format to 2022, with a shorter one held virtually in Spring and a second hybrid meeting with educational content at a convenient venue.

Date of next meeting: To be confirmed by Doodle Poll and held via MS Teams in early 2023

Potential agenda item

-END-