

Developing Effective Pathways to Deliver Quality and Timely Care



Breast Cancer Care Pathway

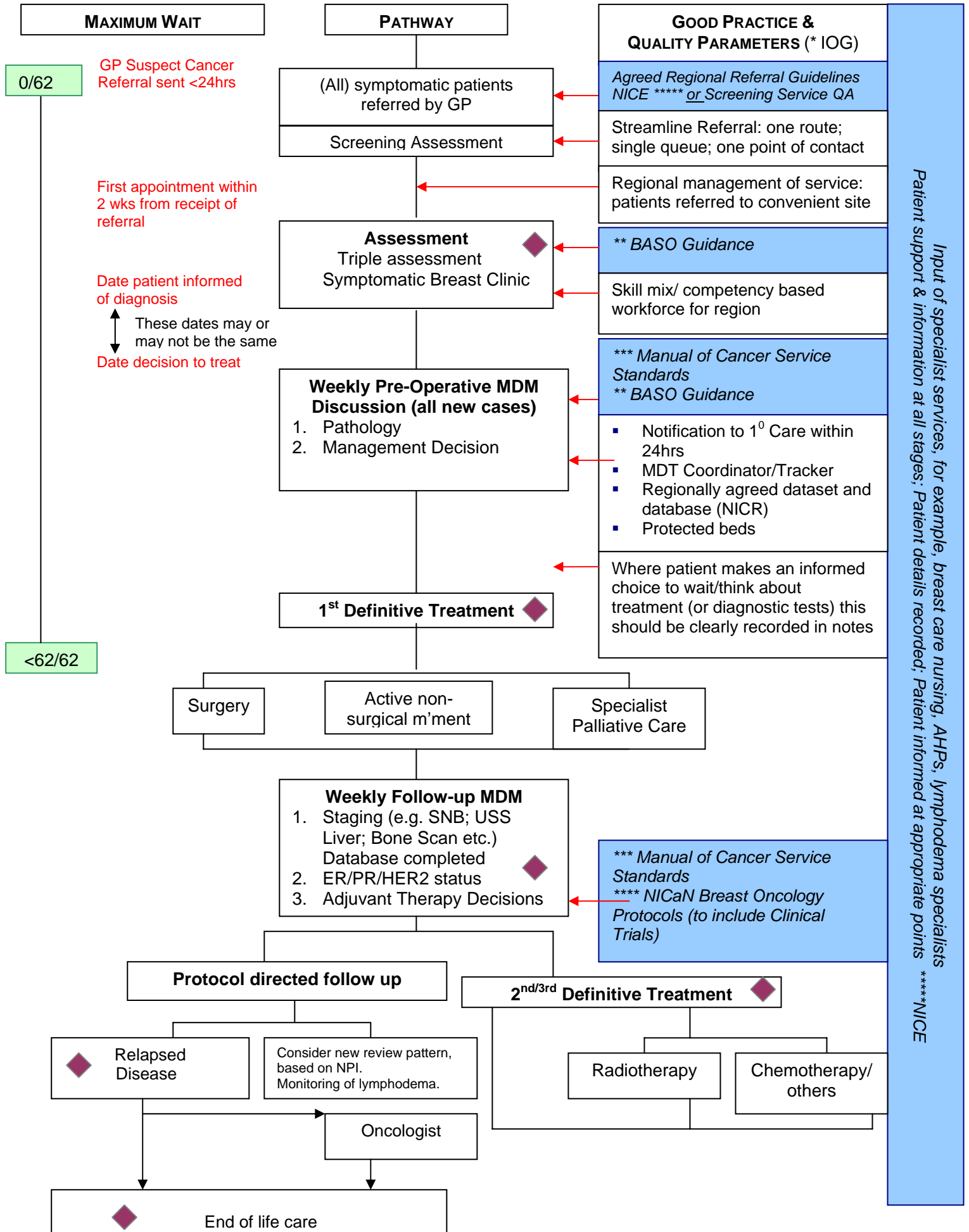
Cancer Care Pathways outline the steps and stages in the patient journey within defined timescales from referral through to diagnostics, staging, treatment, follow up, rehabilitation and if applicable onto palliative care.

The purpose of this pathway document is to provide a clear and concise account of the key stages, diagnostic tests and treatments that are expected to take place for patients who are suspected of having breast cancer.

This work will inform the development of a Service Framework for breast cancer. Service Frameworks will contain the explicit standards underpinned by evidence and legislative requirements and set targets, specific timeframes and expected outcomes.

This pathway was initially prepared by a subgroup of the NICaN Breast Group and discussed at the January, March and May meetings of the NICaN Breast Group. During this period, the pathway has been circulated for comment and consultation to members of the Group and Local Lead Cancer Clinicians.

Outline of Evidence Based Pathway – Breast Cancer



Evidence base for care pathway

- * Implementing Outcomes Guidance: Breast, August 2002
- ** BASO: www.baso.org/downloads/BASOguidelines_2005.pdf
- *** Manual of Cancer Services Standards www.cquins.nhs.uk/manual.php?p=full
- **** Oncology Protocols: Dr A Clayton, Personal Communication
- ***** NICE Improving Supportive and Palliative Care for Adults with Cancer: <http://www.nice.org.uk/page.aspx?o=csgspfullguideline>
- ***** NICE Referral Guidance <http://www.nice.org.uk/CG027>
- ***** Holistic Common Assessment of Supportive and Palliative Care Needs for Adults with Cancer, Kings College London, January 2007

Service Optimisation

There are a number of practical steps that could be taken to improve patients' experience of care and reduce cancer waiting times.

Such steps may include:

- Streamlining the referral route – one route, single queue, one point of contact
- Pooling referrals
- Straight to test
- Combining tests/visits
- Agreed protocols for diagnosis/staging
- Robust booking/scheduling systems
- Competency based workforce development with skill mix and extended roles

2007/2008 PFA Cancer Access Standards

- 98% of patients diagnosed with cancer (decision to treat) should begin their treatment within a maximum of 31 days
- 75% of patients urgently referred with a suspected cancer should begin their first definitive treatment within a maximum of 62 days. Where the performance of a tumour group currently exceeds this standard, performance should be sustained or improved against current levels
- All breast referrals deemed urgent according to regionally agreed guidelines for suspected breast cancer should be seen within two weeks of the receipt of the GP referral

Appendix - Version Control of Draft Pathway:


Following discussions at SubGroup meeting on 12th December, the following changes were proposed:

- 'same-day notification to Primary Care – change to 'notification within 24 hours'.
- notification to NICR – felt to be implicit as part of data collection processes/system
- Add pathology to 1st MDM discussion
- Move 'Further staging Investigations' from 1st MDM to later MDMs. (Surgery is part of staging process).

Points raised by Dr Garvey for consideration / inclusion in pathway.

- Following 1st definitive treatment – patient is referred to specialist palliative care – supportive and palliative care is along entirety of pathway
- Require clarification on protocol follow-up
- Need for clarity on decision to treat, ie what stage within pathway is significant news broken to the patient?
- Need to consider the time lines after diagnosis

Points from Tuesday 6th March 2007 meeting

- Date patient informed of diagnosis is mandatory
 - Date of Decision to Treat: the date which the clinician and the patient discusses and agree the treatment plan
 - Can vary for breast cancer patients, ie prior or after the MDM (90% normally before the MDM).
 - The MDM decision date should be recorded
 - Mandatory/trigger points where there should be evidence of holistic assessment and appropriate referral (holistic patient support) – marked 
- Holistic Common Assessment of Supportive and Palliative Care Needs for Adults with Cancer, Kings College London, January 2007
- Under follow-up, include monitoring of lymphodema
 - Along the entire pathway insert input of specialist services, ie breast care nursing, AHPs, lymphodema specialists etc.

It was noted that at the NICaN Primary Care meeting in November 2006, it was agreed that referrals with a suspicion of cancer would be made within 24 hours

**FILE NOTE OF DISCUSSION AND ACTIONS POINTS FROM
NICAN BREAST CANCER GROUP: PATHWAY SUB-GROUP MEETING;
TUESDAY 12TH DECEMBER 2006; CANCER CENTRE; 3:00-5:00PM**

Attendees

Dr Gavin Briggs	Ms Sandra McKillop
Dr Iain Cameron	Ms Marie McStay
Dr Alison Clayton	Dr Elizabeth Anne Ranaghan
Mr Stephen Kirk	Ms Sigi Refsum
Ms Janis McCulla	Ms Rosey Whittle

Apologies

Ms Elivra Lowe

Ms Sandra McKillop welcomed members and sought clarification on the purpose of the meeting. The following is a record of the key discussion points and actions.

DISCUSSION POINTS

- Ms McKillop shared some of the documentation and evidence regarding effective and high quality breast cancer pathways
 - Breast Cancer Services: Top Tips
Cancer Services Collaborative, NHS
 - Cancer High Impact Changes
Cancer Services Collaborative, NHS. Practical steps to reduce waiting times and improve patient experience.
- **Referral:** On reviewing evidence, Ms Refsum raised point regarding referral process and referenced practice in Wakehurst with respect to the partial booking system. While all referrals are triaged, the criterion used within BCH is not consistent. The process in Ulster and Craigavon was described (single point, daily triage, allocated slots).
- With respect to the referral guidelines, members discussed the criteria for urgent referral, 'palpable lump <30 if clinically suspicious'. After discussing likelihood of malignancy, it was felt that this age threshold would not provide an adequate discriminator and urged reconsideration by the referral subgroup.
- The challenges for adhering to guidance by GPs was acknowledged given the emotive nature of breast cancer services and the well-informed patient. It was felt though that for the system to work, GPs needed to adhere to the guidance. Members felt the need for a public education programme. Ms McCulla proposed that she would raise this with members of the NICaN Cancer Experience Forum/Patient and Public Forum.
- After much discussion, summary conclusions re referral include: there should be a central point for receipt of referrals at each Trust. A system for regional receipt of referrals should be considered. The age threshold for palpable lump needs re-considered. Public health/education programme to be considered with NICaN Patient and Public Forum.

- **Assessment.** There was reference to the work undertaken by group chaired by Mr Kirk and the recommendations regarding minimum standard for a Symptomatic Breast Clinic and numbers of patients to be seen. The report had also outlined a number of short-term, simple and relatively low cost measures, which now should be implemented to allow equity of access, good clinical standards and outcomes across the province.
- Clearly units have developed and implemented various practices to enable more capacity for assessment. The crux of the discussion came to whether members felt capacity for more assessment was required, or capacity to enable all patients to have access to one-stop assessment.
- Mr Kirk commented that such decisions should not be constrained by financial considerations and that the budget for the service has been part of a general surgical budget and the service has thus not received comprehensive funding. Ms McKillop added that the care pathway for the service would need to be fully costed and will provide the specification for future commissioning of cancer services.
- The discussion was not concluded – clearly this is a matter of balance between access, best clinical evidence and efficiency and sustainability of services.
- With respect to the monitoring point ‘Date of Decision to Treat’, i.e. the date of consultation between patient and clinician regarding the planned cancer treatment. Members felt this was the consultation between patient and clinician at the assessment clinic.
[Should the ‘Date of Decision to Treat’ follow the multidisciplinary team meeting? i.e. when the diagnosis and proposed treatment plan has been discussed with all relevant disciplines??]
- **Draft Pathway:** Following discussions, members reflected on changes that should be made to the draft pathway tabled. Specific changes include:
 - ‘same-day notification to Primary Care – change to ‘notification within 24 hours’.
 - Remove notification to NICR –felt to be implicit as part of data collection processes/system
 - Add pathology to 1st MDM discussion
 - Move ‘Further staging Investigations’ from 1st MDM to later MDMs. (Surgery is part of staging process).

ACTIONS AGREED

- File note of meeting to be completed and revisions made to draft pathway. Members of sub group to check their copies of draft pathway to ensure all revisions are made and propose further amendments.

[Draft pathway and discussion points could be prepared for next meeting of NICaN Breast Group on 30th January, 2pm, Lisburn].
- Members to discuss the number of referrals, process for receipt / triage at the next NICaN Breast Group meeting.

This discussion would also offer quality assurance for the data being collated and submitted as part of the Departments performance management of the 2-week wait.