<table>
<thead>
<tr>
<th>Measure No.</th>
<th>Measure Title</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-1C-101b</td>
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<td>13-1C-102b</td>
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<td>5</td>
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<td>13-1C-104b</td>
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<td>13-1C-105b</td>
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<td>Patient Experience</td>
<td>Annual report</td>
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<td>13-1C-108b</td>
<td>Clinical Outcomes Indicators and Audits</td>
<td>Annual Report</td>
</tr>
<tr>
<td>13-1C-109b</td>
<td>Discussion of Clinical Trials</td>
<td>Annual Report</td>
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</tbody>
</table>
1. **INTRODUCTION**

Cancer services in Greater Manchester and East Cheshire changed in 2013/14. The Greater Manchester and Cheshire Cancer Network ceased to exist in March 2013 when cancer networks nationally were amalgamated into strategic clinical networks as part of the NHS reorganisation. In Greater Manchester this coincided with the creation of Manchester Cancer, an integrated cancer system for Greater Manchester and East Cheshire.

Twenty Manchester Cancer Pathway Clinical Directors were appointed in late 2013 and took up their roles on 1st January 2014.

These clinical leaders have formed Pathway Boards, multi-professional clinical groups from across the region. Most Pathway Boards began meeting in spring 2014. For the purposes of the National Cancer Peer Review Programme, Manchester Cancer Pathway Boards are taken to be the *network group* for the relevant tumour type or cancer area.

2. **CONFIGURATION**

2.1 **Local Breast Cancer Teams**

<table>
<thead>
<tr>
<th>Local Breast Cancer Teams</th>
<th>MDT Lead Clinician</th>
<th>CCGs in Catchment</th>
<th>Catchment Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton Hospitals NHS Trust</td>
<td>Mrs Jane Ooi</td>
<td>NHS Bolton CCG</td>
<td>294,600</td>
</tr>
<tr>
<td>East Cheshire NHS Trust</td>
<td>Miss Chandeena Roshanlall</td>
<td>NHS Eastern Cheshire CCG</td>
<td>201,000</td>
</tr>
<tr>
<td>Mid Cheshire NHS Trust</td>
<td>Miss Vanessa Pope</td>
<td>NHS Vale Royal CCG</td>
<td>102,100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS South Cheshire</td>
<td>173,200</td>
</tr>
<tr>
<td>Pennine Acute NHS Trust</td>
<td>Mr Mohamed Absar</td>
<td>NHS Bury CCG</td>
<td>195,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS HM&amp;R CCG</td>
<td>223,300</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS North Manchester CCG</td>
<td>183,200</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS Oldham CCG</td>
<td>239,600</td>
</tr>
<tr>
<td>Salford Royal Foundation Trust</td>
<td>Miss Zahida Saad</td>
<td>NHS Salford CCG</td>
<td>247,600</td>
</tr>
<tr>
<td>Stockport Foundation NHS Trust</td>
<td>Mr Mohammed Sharif</td>
<td>NHS Stockport CCG</td>
<td>299,000</td>
</tr>
<tr>
<td>Tameside Acute NHS Trust</td>
<td>Mr Simon Ellenbogen</td>
<td>NHS Tameside &amp; Glossop CCG</td>
<td>240,300</td>
</tr>
<tr>
<td>University Hospital of South Manchester NHS Trust</td>
<td>Prof Nigel Bundred</td>
<td>NHS Trafford CCG</td>
<td>233,100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS Central Manchester CCG</td>
<td>211,800</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS South Manchester CCG</td>
<td>165,100</td>
</tr>
</tbody>
</table>
The named local Breast teams will carry out the diagnostic process and surgical treatment for symptomatic patients from their own catchment, referring patients to Christie Hospital for radiotherapy, and for chemotherapy if unable to provide locally.

### 2.2 NHS Screening Assessment Units

<table>
<thead>
<tr>
<th>Assessment Unit</th>
<th>Host Trust</th>
<th>CCGs in Catchment</th>
<th>Catchment Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton</td>
<td>Bolton Hospitals NHS Trust</td>
<td>Bolton; Bury; HM&amp;R;</td>
<td>712,900</td>
</tr>
<tr>
<td>Macclesfield</td>
<td>East Cheshire NHS Trust</td>
<td>East Cheshire; Stockport</td>
<td>500,000</td>
</tr>
<tr>
<td>Crewe</td>
<td>Mid Cheshire NHS Trust</td>
<td>Vale Royal, South Cheshire</td>
<td>275,300</td>
</tr>
<tr>
<td>Wigan*</td>
<td>Wrightington, Wigan and Leigh NHS Trust</td>
<td>Wigan Borough</td>
<td>320,300</td>
</tr>
<tr>
<td>Manchester</td>
<td>University Hospital of South Manchester NHS Trust</td>
<td>Salford; Trafford; Oldham; Tameside and Glossop; Manchester</td>
<td>1,520,700</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>3,329,200</strong></td>
</tr>
</tbody>
</table>

*Wigan also screens women from South Lancashire PCT, Lancs & South Cumbria Cancer Network

The named NHS BSP assessment units will carry out the diagnostic process for patients screened within their own catchment. After diagnosis patients, if clinically appropriate, will be offered treatment at the host trust of the assessment centre or may be referred back to their own local trust.

### 2.3 Manchester Cancer

The Greater Manchester and Cheshire Cancer Network is the largest Cancer Network in the country covering a population just over 3.3 million served by the following organisations:

**North West Sector:**
- Wrightington Wigan and Leigh NHS Trust
- Royal Bolton Hospital NHS Foundation Trust
- Salford Royal NHS Foundation Trust

**North East Sector:**
- Pennine Acute Hospitals NHS Trust (Bury, North Manchester, Oldham, Rochdale)
- Central Manchester University Hospitals NHS Foundation Trust (including Trafford Healthcare NHS Trust)

**South Sector:**
The Christie Hospital is the Tertiary Referral Centre for the Cancer Network. Radiotherapy is delivered at Christie Hospital and the satellite radiotherapy units based at Royal Oldham Hospital and Salford Royal.

Some chemotherapy and clinical trials will continue to be delivered from Christie Hospital, although local chemotherapy is currently available at:

- Wigan
- Bolton
- Oldham
- East Cheshire
- Mid Cheshire

2.4 Terms of Reference (13-1C-102b)

These terms of reference were agreed on 1st May 2014 by Jane Ooi, Pathway Clinical Director for Breast Cancer, and Mr David Shackley, Medical Director of Greater Manchester Cancer Services, on behalf of the Greater Manchester Cancer Services Provider Board. The terms of reference will be subject to future review.

2.4.1 The Pathway Board

The Breast Cancer Pathway Board is a cancer care specific board with responsibility to improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire (a catchment population of 3.2 million). This area is synonymous with the old Greater Manchester and Cheshire Cancer Network area.

The Pathway Board is led by a Pathway Clinical Director and is formed of a multidisciplinary team of clinicians and other staff from all of hospital trusts that are involved in the delivery of breast cancer care in Greater Manchester. The Pathway Board also has membership and active participation from primary care and patients representatives.

The Breast Cancer Pathway Board reports into and is ultimately governed and held to account by the Greater Manchester Cancer Services Provider Board.

2.4.2 Greater Manchester Cancer Services Provider Board

The Greater Manchester Cancer Services Provider Board is responsible for the service and clinical delivery arm of Manchester Cancer, Greater Manchester’s integrated cancer system. Manchester Cancer has two other arms: research and education (see appendix for the structure of Manchester Cancer).
The Provider Board is independently chaired and consists of the Chief Executive Officers of the ten acute hospital trusts in the Greater Manchester area:

- Bolton NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- East Cheshire NHS Trust
- Pennine Acute NHS Trust
- Salford Royal NHS Foundation Trust
- Stockport NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust
- The Christie NHS Foundation Trust
- University Hospital of South Manchester NHS Foundation Trust;
- Wrightington, Wigan and Leigh NHS Foundation Trust;

The Provider Board regularly invites representatives of commissioners, the Strategic Clinical Network, and Manchester Cancer to its meetings.

2.4.3 Purpose of the Pathway Board

The purpose of the Pathway Board is to improve cancer care for patients on the Greater Manchester breast cancer pathway. Specifically, the Pathway Board aims to save more lives, put patients at the centre of care, and improve patient experience. The Board will represent the interests of local people with cancer, respecting their wider needs and concerns. It is the primary source of clinical opinion on this pathway for the Greater Manchester Cancer Services Provider Board and Greater Manchester’s cancer commissioners.

The Pathway Board will gain a robust understanding of the key opportunities to improve outcomes and experience by gathering and reviewing intelligence about the breast cancer pathway. It will ensure that objectives are set, with a supporting work programme that drives improvements in clinical care and patient experience.

The Pathway Board will also promote equality of access, choice and quality of care for all patients within Greater Manchester, irrespective of their individual circumstances. The Board will also work with cancer commissioners to provide expert opinion on the design of any commissioning pathways, metrics and specifications.

2.4.4 Role of the Pathway Board

The role of the Breast Cancer Pathway Board is to:

Represent the Greater Manchester Cancer Services professional and patient community for breast cancer.

Identify specific opportunities for improving outcomes and patient experience and convert these into agreed objectives and a prioritised programme of work.

Gain approval from Greater Manchester’s cancer commissioners and the Greater Manchester Cancer Services Provider Board for the programme of work and provide regular reporting on progress.
Design and implement new services for patients where these progress the objectives of commissioners and Greater Manchester Cancer Services, can be resourced, and have been shown to provide improvements in outcomes that matter to patients.

Ensure that diagnosis and treatment guidelines are agreed and followed by all teams in provider trusts, and are annually reviewed.

Ensure that all providers working within the pathway collect the pathway dataset measures to a high standard of data quality and that this data is shared transparently amongst the Pathway Board and beyond.

Promote and develop research and innovation in the pathway, and have agreed objectives in this area.

Monitor performance and improvements in outcomes and patient experience via a pathway scorecard, understanding variation to identify areas for action.

Escalate any clinical concerns through provider trusts.

Highlight any key issues that cannot be resolved within the Pathway Board itself to the Medical Director of Greater Manchester Cancer Services for assistance.

Ensure that decisions, work programmes, and scorecards involve clearly demonstrable patient participation.

Share best practices with other Pathway Boards within Greater Manchester Cancer Services.

Contribute to cross-cutting initiatives (e.g. work streams in living with and beyond cancer and early diagnosis).

Discuss opportunities for improved education and training related to the pathway and implement new educational initiatives.

Develop an annual report of outcomes and patient experience, including an overview of progress, difficulties, peer review data and all relevant key documentation. This report will be published in July of each year and will be the key document for circulation to the Provider Board. A template for this report is available so that all Pathway Boards complete the report in a similar manner.

### 2.4.5 Membership principles

All member organisations of Greater Manchester Cancer Services will have at least one representative on the Pathway Board unless they do not wish to be represented.

Provider trusts not part of Greater Manchester Cancer Services can be represented on the Pathway Board if they have links to the Greater Manchester breast cancer pathway.

All specialties and professions involved in the delivery of the pathway will be represented.

The Board will have at least one patient or carer representative within its membership.
One professional member of the Pathway Board will act as a Patient Advocate, offering support to the patient and carer representative(s).

The Board will have named leads for:

- Early diagnosis
- Pathology
- Radiology
- Surgery
- Oncology
- Specialist nursing
- Living with and beyond cancer (‘survivorship’)
- Research
- Data collection (clinical outcomes/experience and research input).

It is possible for an individual to hold more than one of these posts. The Pathway Clinical Director is responsible for their fair appointment and holding them to account.

These named leads will link with wider Greater Manchester Cancer Services Boards for these areas where they exist.

2.4.6 Network Group Meetings
All members will be expected to attend regular meetings of the Pathway Board to ensure consistency of discussions and decision-making (meeting dates for the whole year will be set annually to allow members to make arrangements for their attendance).

A register of attendance will be kept: members should aim to attend at least 5 of the 6 meetings annually and an individual’s membership of the Pathway Board will be reviewed in the event of frequent non-attendance and/or non-attendance at 2 consecutive meetings.

Each trust member will have a named deputy who will attend on the rare occasions that the member of the Board cannot.

2.4.7 Frequency of meetings
The Breast Cancer Pathway Board will meet every two months.

2.4.8 Quorum
Quorum will be the Pathway Clinical Director plus five members of the Pathway Board or their named deputies.

2.4.9 Communication and engagement
Accurate representative minutes will be taken at all meetings and these will be circulated and then validated at the next meeting of the Board.
All minutes, circulated papers and associated data outputs will be archived and stored by the Pathway Clinical Director and relevant Pathway Manager.

The Pathway Board will design, organise and host at least one open meeting per year for the wider clinical community and local people. This meeting or meetings will include:

- An annual engagement event to account for its progress against its work programme objectives and to obtain input and feedback from the local professional community
- An annual educational event for wider pathway professionals and interested others to allow new developments and learning to be disseminated across the system

Representatives from all sections of the Greater Manchester Cancer Services professional body will be invited to these events, as well as patient and public representatives and voluntary sector partners.

An annual report will be created and circulated to the Medical Director of the Greater Manchester Cancer Services Provider Board by 31st July of each calendar year.

The agendas, minutes and work programmes of the Pathway Board, as well as copies of papers from educational and engagement events, will be made available to all in an open and transparent manner through the Greater Manchester Cancer Services website once this has been developed.

2.4.10 Administrative support

Administrative support will be provided by the relevant Pathway Manager with the support of the Greater Manchester Cancer Services core team. Over the course of a year, an average of one day per week administrative support will be provided.
2.5 Membership (13-1C-101b)

Manchester Cancer Breast Cancer Pathway Board Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Administration</th>
<th>Role</th>
<th>Breast Cancer Pathway Representation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Mohammed Absar*</td>
<td></td>
<td>Consultant Breast Surgeon</td>
<td>Chair (Pennine)</td>
</tr>
<tr>
<td>Melissa Wright</td>
<td></td>
<td></td>
<td>Pathway Manager</td>
</tr>
</tbody>
</table>

**Trust Representatives**

<table>
<thead>
<tr>
<th>Name</th>
<th>Administration</th>
<th>Role</th>
<th>Breast Cancer Pathway Representation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miss Clare Garnsey</td>
<td></td>
<td>Consultant Breast Surgeon</td>
<td>Trust Representative (Bolton)</td>
</tr>
<tr>
<td>Mr Amar Deshpande</td>
<td></td>
<td>Consultant Breast Surgeon</td>
<td>Trust Representative (WWL)</td>
</tr>
<tr>
<td>Miss Vanessa Pope</td>
<td></td>
<td>Consultant Breast Surgeon</td>
<td>Trust Representative (Mid Cheshire)</td>
</tr>
<tr>
<td>Miss Chandeena Roshanlall</td>
<td></td>
<td>Consultant Breast Surgeon</td>
<td>Trust Representative (East Cheshire)</td>
</tr>
<tr>
<td>Miss Zahida Saad</td>
<td></td>
<td>Consultant Breast Surgeon</td>
<td>Trust Representative (Salford)</td>
</tr>
<tr>
<td>Miss Emma Reid</td>
<td></td>
<td>Consultant Radiologist</td>
<td>Trust Representative (Stockport)</td>
</tr>
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**Histopathology Representatives**

<table>
<thead>
<tr>
<th>Name</th>
<th>Administration</th>
<th>Role</th>
</tr>
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<tbody>
<tr>
<td>Dr Mark Pearson</td>
<td></td>
<td>Consultant Histopathologist</td>
</tr>
<tr>
<td>Dr Miles Howe</td>
<td></td>
<td>Consultant Histopathologist and Pathology QA Lead</td>
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**Oncology Representatives**

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<thead>
<tr>
<th>Name</th>
<th>Administration</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Brian Magee</td>
<td></td>
<td>Consultant in Clinical Oncology</td>
</tr>
<tr>
<td>Dr Anne Armstrong</td>
<td></td>
<td>Consultant in Medical Oncology</td>
</tr>
</tbody>
</table>

**Radiology Representatives**

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<thead>
<tr>
<th>Name</th>
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<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Michael Crotch-Harvey</td>
<td>Programme Director East Cheshire and Stockport NHSBSP</td>
<td>Radiology Representative</td>
</tr>
<tr>
<td>Dr Gillian Hutchison</td>
<td>Programme Director Bolton, Bury and Rochdale NHSBSP</td>
<td>Radiology Representative</td>
</tr>
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**Allied Health Care Professionals**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clare Brearley</td>
<td>Advanced Nurse Practitioner</td>
</tr>
<tr>
<td>Clare Gaskell</td>
<td>Breast Care Nurse</td>
</tr>
<tr>
<td>Karen Livingstone</td>
<td>Specialist Breast Care Physiotherapist</td>
</tr>
<tr>
<td>Other Stakeholders</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>---</td>
</tr>
<tr>
<td>tbc</td>
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<table>
<thead>
<tr>
<th>Research Representative</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Prof Nigel Bundred</td>
<td>Consultant Breast Surgeon</td>
</tr>
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<table>
<thead>
<tr>
<th>Pathway Representatives</th>
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</thead>
<tbody>
<tr>
<td>tbc</td>
<td>Screening and PHE Representative</td>
</tr>
<tr>
<td>Coral Higgins</td>
<td>Cancer Commissioning Manager, NHS Manchester North, Central and South Clinical Commissioning Group’s</td>
</tr>
<tr>
<td>Tara Breslin</td>
<td>Primary Care Representative</td>
</tr>
<tr>
<td>Tarek Baht</td>
<td>Primary Care Representative</td>
</tr>
<tr>
<td>Amanda Myerscough</td>
<td>Primary Care Representative</td>
</tr>
</tbody>
</table>

<table>
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<tbody>
<tr>
<td>David Makin</td>
<td>Patient Representative</td>
</tr>
<tr>
<td>tbc</td>
<td></td>
</tr>
</tbody>
</table>

*From 1\textsuperscript{st} June 2015. Prior to this post held by Mrs Jane Ooi (Bolton)*
3. **PATHWAYS AND GUIDELINES (13-1C-104b)**

Manchester Cancer Pathway Boards have been in place since spring 2014 and are going through the process of reviewing the clinical guidelines and patient pathways inherited from the old cancer network groups.

Where they exist, updated guidelines and pathways have been posted to the relevant pages of the Manchester Cancer website [www.manchestercancer.org](http://www.manchestercancer.org).

Where guidelines and pathways are yet to be reviewed and updated then the legacy documents from the cancer network continue to be current. Where they exist, these legacy documents have also been posted to the relevant pages of the Manchester Cancer website [www.manchestercancer.org](http://www.manchestercancer.org).

3.1 **Primary Care Guidelines for Referral of Patients with Suspected Breast Cancer**

Best Practice Diagnostic Guidelines for patients presenting with breast symptoms; DH publication gateway reference 13737; Willett et al, November 2010

Patients with the following symptoms or signs should be referred for assessment. All patients referred to the breast clinic should receive an appointment within 2 weeks of the date of receipt of referral. Symptoms suggestive of urgent attention are denoted as U, and symptoms considered non-urgent but still requiring an appointment within two weeks are denoted as NU. Family history referrals and cosmetic referrals are excluded from the two week wait pathway.

**Lumps, lumpiness & change in texture**
- Discrete lump in any women 30 years and older that persists after next period or presents after menopause (U)

**At any age:**
- Discrete hard lump with fixation +/- skin tethering / dimpling / altered contour (U)
- A lump that enlarges (U)
- A persistent focal area of lumpiness or focal change in breast texture (U)
- Progressive change in breast size with signs of oedema (U)
- Skin distortion (U)
- Previous history of breast cancer with a new lump or suspicious symptoms (U)

**Under 30 years:**
- A lump that does not meet the above criteria (NU)

**Male patients:**
- Over 50 years with unilateral firm subareolar mass +/- nipple discharge or associated skin changes (U)
Nipple symptoms
- Spontaneous unilateral blood stained nipple discharge (U)
- Unilateral nipple eczema or nipple change that does not respond to topical treatment (U)
- Recent nipple retraction or distortion (U)

Women who can be managed at least initially by GP
- Women under 50 years who have nipple discharge that is from multiple ducts or is intermittent and is neither bloodstained nor troublesome (NU)

Breast Pain
- Patient with minor / moderate degree of breast pain with no discrete palpable abnormality, when initial treatment fails and / or with unexplained persistent symptoms (NU)

Axillary lump (in absence of clinical breast abnormality)
- Persistent unexplained axillary swelling (U)

Communication
Role of the GP:
- The general practitioner plays a fundamental role in supporting the management of symptomatic breast patients. They are supported in their decision to refer (and to re-refer where necessary) by the existence of national guidelines. General practitioners are well placed to support the patient through the referral process, by providing choice and information, and also through any subsequent treatment phases by providing ongoing holistic support. They are often seen as the first port of call by the patient.

Presentation of the patient with new breast symptoms:
- In the initial consultation the GP should assess the patient with a view to referral to a symptomatic breast clinic. The GP may find that the patient has normal or benign changes that do not require referral and, at this point, they should give reassurance supported with the appropriate literature.
- All patients should be aware of present breast screening process and informed not to await their next screening appointment if they develop symptoms

Referral to the clinic:
- Once the patient is referred to the breast clinic, clear communication between professionals is vital at this point to ensure that all relevant information regarding the patient is relayed to the clinic prior to the patients clinic attendance
- The patient should receive written and/or verbal information regarding the symptomatic breast clinic. This information should include waiting times for an appointment and the likely process that will occur during the clinic. This information may be sent out with the appointment letter and should ideally also include information on length of visit
- The patient should also be provided with guidance for obtaining further information
- Patients should be reminded of the importance of keeping their appointment.

3.2 Network Referral Guidelines for patients moving between teams

Screening patients being referred for treatment

- After assessment for screen detected breast cancer, if clinically appropriate, patients should be offered the choice of staying for treatment at the assessment unit or being transferred to their local hospital.
- All patients with newly diagnosed screen detected breast cancer will be discussed at a full MDT meeting at the screening assessment centre.
- If a patient is to be referred to another MDT for treatment, the referring consultant from the screening assessment centre should fax a referral letter within 24 hours of the discussion with the patient, to the receiving MDT.
- The Communication & Referral Protocol (CaRP) documentation must also be completed and sent to the Cancer Services Department at the receiving hospital.
- Patients must begin their first treatment within 62 days of the first screening appointment.
- Referring clinicians should ensure that all relevant information is provided to allow the treating clinical team to meet this target.

<table>
<thead>
<tr>
<th>Screening Unit</th>
<th>Which CCGs screened</th>
<th>Offer patients referral back to local symptomatic units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wigan</td>
<td>Wigan Borough</td>
<td>NA – stay at Wigan</td>
</tr>
<tr>
<td>Bolton</td>
<td>Bolton</td>
<td>NA – stay at Bolton</td>
</tr>
<tr>
<td></td>
<td>Bury</td>
<td>North Manchester</td>
</tr>
<tr>
<td></td>
<td>HM&amp;R</td>
<td>Oldham</td>
</tr>
<tr>
<td>Manchester</td>
<td>Salford</td>
<td>Salford</td>
</tr>
<tr>
<td></td>
<td>Trafford</td>
<td>NA – no breast unit at Trafford</td>
</tr>
<tr>
<td></td>
<td>Oldham</td>
<td>Oldham</td>
</tr>
<tr>
<td></td>
<td>Central Manchester</td>
<td>NA – stay at Manchester</td>
</tr>
<tr>
<td></td>
<td>North Manchester</td>
<td>NA – stay at Manchester</td>
</tr>
<tr>
<td></td>
<td>South Manchester</td>
<td>NA – stay at Manchester</td>
</tr>
<tr>
<td></td>
<td>Tameside &amp; Glossop</td>
<td>Tameside</td>
</tr>
<tr>
<td>Macclesfield</td>
<td>Eastern Cheshire</td>
<td>NA – stay at East Cheshire</td>
</tr>
<tr>
<td></td>
<td>Stockport</td>
<td>Stockport</td>
</tr>
<tr>
<td>Crewe</td>
<td>Vale Royal</td>
<td>NA – stay at Mid Cheshire</td>
</tr>
<tr>
<td></td>
<td>South Cheshire</td>
<td></td>
</tr>
</tbody>
</table>

Referring patients for follow up

- If patients choose to move to a different MDT for clinical follow up the referring clinician should ensure that all relevant information is provided to allow the continuity of care between the two teams.
Referring patients to oncologists

- All patients with newly diagnosed or recurrent breast cancer will be discussed at a full MDT meeting.
- Patients who are thought to require adjuvant treatment should be referred to the core oncology MDT member within 24 hours of the discussion with the patient.
- The referring MDT should fax a referral letter within 24 hours of the discussion with the patient, to the receiving MDT.
- The Communication & Referral Protocol (CaRP) documentation must also be completed and sent to the Cancer Services Department at the Christie hospital.
- Patients must begin their first treatment within 62 days of the initial decision to refer or to upgrade.
- Patients must begin their second or subsequent treatment within 31 days of the earliest clinically appropriate date (ECAD).
- Referring clinicians should ensure that all relevant information is provided to allow the treating clinical team to meet this target.

Referring patients for reconstruction

- If a patient is to be referred to a surgeon from another MDT to discuss options for immediate breast reconstruction, the referring consultant should fax a letter within 24 hours following the discussion with the patient.
- If a patient is to be referred to a surgeon from another MDT to discuss options for delayed breast reconstruction, the referring consultant should fax a letter following the discussion with the patient. Delayed reconstruction is elective surgery and forms part of the 18 week pathway.
- Patients who are being referred for immediate breast reconstruction must begin their treatment within 62 days of the initial GP referral, consultant upgrade, or decision to recall for screening assessment.
- The Communication & Referral Protocol (CaRP) documentation must also be completed and sent to the Cancer Services Department at the receiving hospital.
- Referring clinicians should ensure that all relevant information is provided to allow the treating clinical team to meet this target.
- The above process is followed for patients occasionally referred to plastic surgeons outside this Network, e.g. To Mersey & Cheshire Cancer Network.

Referring patients for Sentinel Lymph Node Biopsy (SLNB)

- If a patient is to be referred to a surgeon from another MDT to discuss options for SLNB as part of their treatment, the referring consultant should fax a letter within 24 hours following the discussion with the patient.
- Patients who are being referred for SLNB must begin their treatment within 62 days of the initial GP referral, consultant upgrade, or decision to recall for screening assessment.
• Patients who are being referred for SLNB (second or subsequent treatment) must begin their treatment within 31 days of the earliest clinically appropriate date (ECAD)
• The Communication & Referral Protocol (CaRP) documentation must also be completed and sent to the Cancer Services Department at the receiving hospital.
• Referring clinicians should ensure that all relevant information is provided to allow the treating clinical team to meet this target.

Core Referral Information

The following information must be included in all referral letters to facilitate patients being processed by the receiving hospitals and to avoid unnecessary delays:
• Patient demographics
• Route of referral & grade
• Date of referral / consultant upgrade / decision to recall for screening assessment
• Date of diagnosis
• Surgical treatment type
• Date of first treatment
• Tumour details
• Node status
• Hormone receptor status
• HER-2 status
• Adjuvant treatment
• Hormone treatment

3.3 Network Imaging Guidelines

The following guidelines have been reviewed and agreed by the Breast NSSG members on 29 June 2011:
• Best Practice Diagnostic Guidelines for Patients Presenting with Breast symptoms, Willet AM, Michell MJ, Lee MJR November 2010
• Royal College of Radiologists, Guidance on Screening and Symptomatic Breast Imaging, April 2005
• Royal College of Radiologists, Breast Imaging Classification, April 2005

3.4 Network Pathology Guidelines

The following guidelines have been reviewed and agreed by the Breast NSSG members on 29 June 2011:
• Royal College of Pathologists & NHS Breast Screening Programme, Pathology Reporting of Breast Disease, January 2005
• Royal College of Pathologists, Tissue Pathways for breast pathology, April 2009
• NHS BSP Non-operative diagnosis guidelines (2001 – but being updated)
• RA Walker, JMS Bartlett, M Dowsett, IO Ellis, AM Hanby, B Jasani, K Miller, SE Pinder
• HER2 testing in the UK: consensus from a national consultation. J Clin Path June 2007, 60: 685-689; M Dowsett, AM Hanby, R Laing, R Walker

3.5 Network Follow Up Guidelines

Purpose of Follow Up

• Detection and treatment of local recurrence and new cancers in the breast
• Management of adverse effects of treatment
• Provide psychological support for affected women
• The majority of recurrences occur in 25% of women within 3 years of original diagnosis

Planned Clinical Follow Up

• Staff groups responsible for planned follow up: Consultant Surgeon, Consultant Oncologist, Clinical Nurse Specialist, Advanced Practitioner Radiographers
• Follow up does not have to be consultant led. Units should be encouraged to have Specialist Practitioner led follow up also.
• The frequency of follow up visits will be stratified by risk of recurrence. Patient led follow up should be encouraged
• A choice of follow up methods may be offered depending on local availability, eg. Primary care based / via telephone contact / consultant or CNS led
• Follow up for adjuvant therapy patients will be between the local surgeon and the oncologist as per local policy
• Endocrine therapy to reviewed by a specialist clinician during or after completion of 5 years therapy

Mammographic Follow Up

• There is a Health Technology Assessment review of breast imaging at present.

Following breast cancer surgery

• Imaging surveillance should be arranged following MDT discussion via the breast imaging specialist (consultant radiologist, specialist radiography practitioner)
• Imaging will be organized as per local protocols
• Mammograms AT LEAST 2-yearly post treatment, up to 10 years or until age 50 (whichever is longer)
• At age 50 or after 10 years follow up, discharge back to the NHS Breast Screening Programme
Patients over the age of 73 should be encouraged to self refer for screening mammography, currently every 3 years.

**Patient requested follow up visits**
- Patients requesting follow up or visits between planned follow up appointments should contact their breast cancer nurse / key worker or GP in the first instance.
- Patients should be given contact details for their breast cancer nurse or key worker at diagnosis.
- If the patient’s concerns cannot be dealt with on the telephone, the patient should be referred back to the GP or be seen in the appropriate breast specialist led outpatient clinic, as soon as possible. This could be the consultant surgeon, consultant oncologist, or specialist practitioner depending on the nature of the concern.

**Written Care Plan**
- A written care plan including a predicted schedule of contact and imaging appointments is being developed by the Breast CSG and will be trialed during 2010.
3.6 Network Wide Protocols for Follow up after Breast Cancer Treatment

Invasive Breast Cancer

Prior to 12 months, consider End of Treatment counseling and survivorship issues

- **Patient 12 months post-op**
  - **Age <50yrs**
    - Years 1 to 5 post op
      - **Annual Breast Practitioner Follow Up years 1 to 3, plus at least year 5 if on endocrine treatment**
      - Annual Mammography
      - Years 6 to 10 post op
      - Refer to Breast Practitioner follow up clinic if concerned
    - Years 6 to 10 post op
  - **Age ≥50yrs**
    - Years 1 to 5 post op
      - **Annual Breast Practitioner Follow Up years 1 to 3, plus at least year 5 if on endocrine treatment**
      - Annual Mammography
      - Years 6 to 10 post op
      - Refer to Breast Practitioner follow up clinic if concerned
    - Years 6 to 10 post op

- **PATIENT REACHES AGE 50**

- **DISCHARGE BACK TO NHS BSP**

- **Annual Breast Practitioner Follow Up years 1 to 3, plus at least year 5 if on endocrine treatment**
  - Annual Mammography
  - Consider support for Survivorship issues, eg. Patient questionnaire, telephone consultation, patient initiated open access
  - Years 6 to 10 post op
  - Refer to Breast Practitioner follow up clinic if concerned

- **Biennial Mammography or NHS BSP as per risk & local protocol**
  - Consider support for Survivorship issues, eg. Patient questionnaire, telephone consultation, patient initiated open access
  - Years 6 to 10 post op
  - Refer to Breast Practitioner follow up clinic

- **DISCHARGE BACK TO NHS BSP**

- **PATIENT REACHES AGE 50**

- **DISCHARGE BACK TO NHS BSP**
Ductal Carcinoma In Situ

Prior to 12 months, consider End of Treatment counseling and survivorship issues

Patient 12 months post-op

Age <50yrs

Years 1 to 5 post op

Annual Breast Practitioner Follow Up after 1 year to assess cosmetic & functional outcome post surgery and radiotherapy

Annual Mammography

Consider support for Survivorship issues, eg. Patient questionnaire, telephone consultation, patient initiated open access

Years 6 to 10 post op

PATIENT REACHES AGE 50

Age ≥50yrs

Years 1 to 5 post op

Annual Breast Practitioner Follow Up after 1 year to assess cosmetic & functional outcome post surgery and radiotherapy

Annual Mammography

Years 6 to 10 post op

Biennial Mammography or NHS BSP as per risk & local protocol

Consider support for Survivorship issues, eg. Patient questionnaire, telephone consultation, patient initiated open access

Years 6 to 10 post op

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Annual Breast Practitioner Follow Up after 1 year to assess cosmetic & functional outcome post surgery and radiotherapy

Annual Mammography

Years 6 to 10 post op

Biennial Mammography or NHS BSP as per risk & local protocol

Consider support for Survivorship issues, eg. Patient questionnaire, telephone consultation, patient initiated open access

Years 6 to 10 post op

DISCHARGE BACK TO NHS BSP

PATIENT REACHES AGE 50
Notes:

Follow up mammograms should be reported in a timely fashion to reduce patient anxiety.

The Breast NSSG recommends using the NHS BSP QA standard of writing to patients with a result within 3 weeks of the mammogram.

Patients with an abnormality detected either clinically or by mammogram should have investigations arranged in a timely fashion.

Ideally patient should be seen in the next available one-stop breast clinic, and further management should be arranged as per the 31-day pathway.

3.7 TYA Pathways

For the teenage and young adult cancer pathways developed under the old Greater Manchester and Cheshire Cancer Network see http://manchestercancer.org/services/teenagers-and-young-adults/

3.8 Chemotherapy Treatment Algorithms (13-1C-105b)

All chemotherapy algorithms can be accessed via the intranet of The Christie NHS Foundation Trust. These are live documents:


Search for:
Policies & Guidelines

Sub-category 1:
Chemotherapy protocols
Breast Cancer Pathway
62 day target for patients referred as suspected cancer

This pathway applies to all patients referred as suspected cancer by their GP, and any patients diagnosed with cancer after routine referral. The 31 day target applies to 2\textsuperscript{nd} and subsequent treatments.

**Events after first treatment are now subject to CWT monitoring since CRS recommendations were implemented in 2008**

**18 April 2013**
Breast Cancer Pathway
Patients with Screen Detected Breast Cancer

This pathway applies to all patients with breast cancer diagnosed from the NHS Breast Screening Programme

Patient attends for breast screening mammogram → Abnormal film read
Day 0
Assessment letter generated → Patient sent results or recall letter
≤ Day 14
Patient asked to attend assessment centre for repeat / further investigations → Attend for assessment
≤ By Day 21
Repeat mammograms
USS
Core Biopsy
Mammatome

Diagnostic MDT
By Day 28
Discuss findings from assessment investigations
Decide treatment options and location of treatment (stay with unit or refer back to local hospital)
Refer for surgical assessment

Surgical Assessment Appointment & Decision to Treat
Day 31
Discuss findings from assessment and cytology / histology results +/− receptors
Discuss treatment options with patient.
CaRP form to be completed if patient is referred to Christie or to other tertiary unit for treatment or opinion

First Treatment
By Day 62
• Admit for surgery
• Start pre-op chemo
• Prescribe endocrine therapy

18 April 2013

BSP QA Standard:
2 weeks from screening to results letter

BSP QA Standard:
3 weeks from screening to 1st assessment appointment