**DOCUMENTATION**

**Document Location**

The document is located:
1. The Central South Coast Cancer Network office, in hardcopy and electronic format
2. Website [www.csccn.nhs.uk](http://www.csccn.nhs.uk)
3. Individual Trust Cancer Departments and websites

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### Revision History

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<th>Date</th>
<th>Version</th>
<th>Status</th>
<th>Author</th>
<th>Summary of Changes</th>
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<td>3.10.10</td>
<td>2010.1D</td>
<td>Draft</td>
<td>W. Keating</td>
<td>Update MDT Leads&lt;br&gt;Insert Sp Pall Care Pathway and CYP Pathway&lt;br&gt;Update Cancer Waiting Times</td>
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<td>2010.2D</td>
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<td>Flowchart updated (KH)</td>
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<td>NSSG</td>
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<td>Revised</td>
<td>NSSG</td>
<td>Update flow chart as agreed NSSG 11 07 11</td>
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<td>2011.3</td>
<td>Revised</td>
<td>WK</td>
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### Approvals Record

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<table>
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<th>Name / Title</th>
<th>Signature</th>
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<tr>
<td></td>
<td>11 07 11</td>
<td>Mr Kevin Harris, NSSG Chair, Consultant Breast Surgeon Basingstoke &amp; North Hampshire NHS Foundation Trust MDT Lead Clinician</td>
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<td></td>
<td>11 07 11</td>
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<td>11 07 11</td>
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<td></td>
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Date of next review - 2013

This item is to be reviewed on a bi-annual basis, or on release of revised guidelines.

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Acknowledgement and thanks to Kent and Medway Cancer Network for allowing the use of this document framework.
1.0 Background

Cancer Networks are based around patient pathways and these are founded on the relationship between primary care, cancer units and cancer centres. The key to this relationship is the fact that many patient pathways pass through three or more organisational boundaries, and often require the services of cancer services for highly specialist surgery, complex chemotherapy or radiotherapy. It is crucial to the patient experience that these pathways are joined up and that there is the correct balance of local and supra specialist provision to ensure that patients move along the pathway and experience consistent standards of care regardless of the provider.

The Central South Coast Cancer Network provides care for 2.2 million population with 14,000 people registered with cancer annually. The constituent members of the network are provider Trusts, Primary Care Trusts, Independent Sector, Voluntary Sector (Charities and Hospices), Channel Islands and the Strategic Health Authority. Each of the hospital Trusts within the network has an independent multi-disciplinary team and provide local surgery and chemotherapy. Radiotherapy is provided at Southampton University Hospitals Trust and Portsmouth Hospitals NHS Trust.

Cancer Care Pathways outline the steps and stages in the patient journey within defined timescales from referral through to diagnostics, staging, treatment, follow up and if applicable onto palliative care. A wide range of healthcare providers contribute to and are involved in the delivery of care pathways.

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.

The main reference documents which support this pathway document and which have been adopted as guidelines by the Central South Coast Cancer Network Breast Site Specific Group are:

1. National Institute for Clinical Excellence ‘Early and Locally Advanced Breast Cancer: Diagnosis and Treatment’ (Clinical Guideline 80, February 2009) available:
   http://www.nice.org.uk/guidance/CG80

2. National Institute for Clinical Excellence ‘Advanced Breast Cancer: Diagnosis and Treatment’ (Clinical Guideline 81, February 2009) available:
   http://guidance.nice.org.uk/CG81

   http://guidance.nice.org.uk/CG41

   http://www.nice.org.uk/guidance/qualitystandards/breastcancer/home.jsp

5. National Institute for Clinical Excellence NICE Breast Cancer Care Pathway which is available at:
   http://pathways.nice.org.uk/pathways/breast-cancer

The local organisation of Breast Care Services is described within the local operational policy documents for each Trust.
Symptomatic Breast Patient Pathway

Other Referral Sources include; Radiology Non-Breast Hospital Consultants

Patient sees GP referred to service using 2 week wait referral guidance

Patient attends hospital Out Patient Clinic/One Stop Clinic
All patients should undergo "Triple Assessment"

Referral via Breast Screening Service

Mammogram

Ultrasound

Fine Needle Biopsy
Cytology and/or Core Biopsy

Multi Disciplinary Team discussion of diagnostic results

May require further investigations e.g. MRI

-ve

Clinic Review with patient, discussion of results and treatment options with CNS

Treatment/Management Decision

Surgery

Chemotherapy/ Radiotherapy

Hormone Therapy

Palliative Care

Follow up

Reassure and discharge letter to GP

Flowchart updated and agreed by NSSG 11 07 11
3.0 Agreed referral criteria

The National Institute for Health and Clinical Excellence (NICE) referral guidelines for suspected cancer (Clinical Guideline 27 June 2005) document details the referral criteria for patients who present with symptoms suggestive of breast cancer to a team specialising in the management of breast cancer, depending on local arrangements.

Breast – As agreed in the referral guidelines for breast cancer –

- A new discrete lump in a patient over 30 years of age
- Observable asymmetry or puckering
- Nipple disease
- Nipple discharge, unilateral or blood stained
- Axillary lymphadenopathy
- Other definitive evidence of cancer at any age
- Recurrence

3.2.1 Primary Care Referral

The Breast NSSG agreed (22.7.09) to continue to adopt the National Institute for Health and Clinical Excellence ‘Referral guidelines for suspected cancer’ (Clinical Guideline 27, June 2005 pp23-25) available:

http://guidance.nice.org.uk/CG27

Additionally the group agreed (22.7.09) that in line with the Going Further on Cancer Waits (Cancer Reform Strategy, 2007) all patients with breast symptoms should be assessed within two weeks (from Dec 2009), all patients being referred by screening services to be treated within the 62 day standard, and all specialist upgrades to enter the 62 day pathway.

Family history:

A risk assessment should be undertaken to categorise patients into low, intermediate or high risk groups according to local Cancer Genetics Guidelines. High risk and moderate risk groups should undergo annual screening mammography from age 40-50 in line with NICE guidance. Over the age of 50 patients should be screened by the routine NHS breast screening service as a minimum.

4.0 Cancer waiting times

The Cancer Waiting Times, Communication and Referral Protocol (CaRP) document outlines the broad information transfer principles that the Trusts within Central South Coast Cancer Network should adhere to when tracking and transferring care of patients. The focus of the CaRP document is the transfer of information between Trusts to support and facilitate the treating of patients within the target times, specific Trust data quality and cancer waiting times upload issues.

The CaRP document addresses the following key areas:

- Why the information needs to be communicated
- Who is responsible for communicating the information
- What information needs to be communicated
- When the information needs to be communicated
- How the information should be communicated

The CARP document is available on the Central South Coast Cancer Network website: http://www.csccn.nhs.uk
Cancer Waiting Times Standards

2 week wait – maximum two week (14 days) wait for all patients with symptoms of breast disease

31 day – maximum one month (31 days) wait from diagnosis (decision to treat) to first definitive or subsequent treatment (start date for all cancers)*

62 day – maximum two month (62 days) wait from urgent GP referral or Consultant upgrade for suspected cancer to first definitive treatment (start date) for all cancers.

Each Trust has identified key areas where tracking, navigation and escalation of patients on the pathway occur. These can include:

- GP referral
- Passage onto Out Patients
- Passage out of Out Patients
- Diagnostic Pathway
- Passage to Multi-disciplinary Team and Decision to Treat
- Confirmation and start of treatment

The 31 day and 62 day standards demand careful review of the pathway and timing of appointments and Multi-disciplinary Team discussions for breast cancer. The time-scale may be as follows:

<table>
<thead>
<tr>
<th>EVENTS</th>
<th>ACTIONS</th>
<th>STAFF</th>
<th>BY DAY</th>
<th>Communication</th>
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<tbody>
<tr>
<td>GP Appointment</td>
<td>GP sees patient and refers</td>
<td>GP</td>
<td>0</td>
<td>GP to patient</td>
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<tr>
<td>2 week wait referral faxed to Hospital</td>
<td>GP</td>
<td>1</td>
<td>Fax back to GPs within 24 hrs</td>
<td></td>
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<tr>
<td>Out Patient Clinic/One stop Out patient clinic</td>
<td>Patient seen in out patient clinic and undergoes “Triple Assessment”</td>
<td>Consultant Clinical Nurse Specialist</td>
<td>14</td>
<td></td>
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<tr>
<td>Patient identified</td>
<td>MDT Co-ordinator</td>
<td>14</td>
<td>Identified by tracker</td>
<td></td>
</tr>
<tr>
<td>Diagnostics</td>
<td>Processing and reporting time</td>
<td>Imaging</td>
<td>14-21</td>
<td></td>
</tr>
<tr>
<td>Processing and reporting time</td>
<td>Histopathology</td>
<td>14-21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOCAL MDT</td>
<td>Diagnosis confirmed</td>
<td>LOCAL MDT TEAM</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Staging recommendations</td>
<td>GP informed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment options defined</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic Review with Patient</td>
<td>PATIENT INFORMED OF DIAGNOSIS, STAGING NEEDS, TREATMENT OPTIONS.</td>
<td>As local arrangement</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Patient referred for surgical opinion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient referred radiotherapy</td>
<td></td>
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<tr>
<td>Patient referred for chemotherapy</td>
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<tr>
<td>Patient referred for palliative care</td>
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<td>Pre-operative Assessment</td>
<td>As local arrangement</td>
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<tr>
<td>Treatment</td>
<td>Surgery</td>
<td>62</td>
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<tr>
<td>Radiotherapy</td>
<td>62</td>
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<tr>
<td>Chemotherapy</td>
<td>62</td>
<td></td>
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</tr>
<tr>
<td>Palliative Care</td>
<td>62</td>
<td></td>
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</tbody>
</table>
5.0 **Breast cancer patient assessment**

The patient attends the hospital outpatient clinic and is reviewed by the breast care team. The patient has "triple assessment"; clinical history and examination, imaging and cytology or histopathology as appropriate.

The patient will have a key worker/contact allocated and further diagnostics booked as appropriate.

6.0 **Diagnostics**

**Diagnosis**

- All new patients with diagnosis of cancer to be discussed at the multi-disciplinary meeting pre-operatively
- All patients with diagnosis of cancer to be referred to breast care nurse and a key worker identified and recorded in the clinical notes.

**Radiology**

**Imaging Guidelines 08-1C-105b**

The Breast NSSG agreed (22.7.09) to adopt the Royal College of Radiologists’ Recommendations for Cross-Sectional Imaging in Cancer Management (Aug 2006 pp.124-126), which is available at:


**Pathology**

**Pathology Guidelines 08-1C-106b**

The Breast NSSG agreed (22.7.09) to adopt the Royal College of Pathologists ‘Dataset for breast cancer histopathology reports’ (October 2005) and reporting guidelines, which are available at:

1. Pathology reporting of breast disease A joint NHSBSP/RCPath publication (1st on the attached link below and no 58 on NHSBSP publications list)


And also agreed to adopt:

2. Guidelines for non-operative diagnostic procedures and reporting in breast cancer screening

NHSBSP publication no 50 (available on NHSBSP publications site)

http://www.cancerscreening.nhs.uk/breastscreen/publications/qa-08.html

7.0 **Breast multi-disciplinary team meeting**

All new patients with a diagnosis of breast cancer will be discussed and their management agreed at the weekly Multi-disciplinary team (MDT) meeting. All relevant documentation including the radiological and pathological information is available at the MDT meeting. Other patients will be discussed as and when necessary throughout the patient journey.

The MDT aims to ensure:

- Designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team’s operational policies are multidisciplinary decisions.
- Care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance/audit.
• Mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent.

The team will consist of core and extended members and all members will have access to the MDT. Lead consultants are expected to attend 67% of the meetings and formal arrangements exist to cover leave of absence of all core members. A team member representative from the MDT is also required to attend at least 67% of the network site specific group meetings.

One core member will be responsible for patient and carer issues and one for the integration of service improvement. Patients and carers will have access to team members via the nurse specialist or the consultants’ secretarial staff and all patients will be given the contact details of the breast cancer nurse specialist(s). Each patient discussed at the MDT meeting should have a key worker/contact allocated and (this must be agreed with the patient) and named in their case notes. The patient’s GP should be informed of the key worker contact details and the patient should receive written information of how to contact the key worker.

The clinical nurse specialist plays a fundamental and pivotal role in assessing and meeting the needs of patients and carers and in signposting patients to other services. They provide information and support to patients, relatives and carers through all the stages of the care pathway ensuring continuity of care at each stage of care including primary, secondary, tertiary and palliative care settings.

• They undertake holistic assessment at key points in the patient pathway
• Apply specialist practice, knowledge and skills to improve the quality of care for patients and their families
• Contribute to multidisciplinary discussion and decision making
• Ensure patients and appropriate relatives and carers are well informed and actively involved in decisions related to care
• Actively participate in the provision of education of patients, relatives and carers

A breast care nurse will be available to see all patients and family if appropriate at the time of diagnosis of cancer. All patients will have contact details of a breast care nurse. Appropriate and up to date verbal and written information will be offered throughout the treatment pathway.

The provision of psychological, psychiatric, lymphoedema management and home visits are desirable as good practice, however are not funded and available throughout the Network. Where available these should be offered. Breast care nurses will have access to lymphoedema management or signposting or information for education and treatment of patients. This may involve physiotherapy referral at the discretion of the breast care nurse. See Central South Coast Cancer Network “Guidelines for the Management of Lymphoedema” 1st Edition (January 2007).

A business meeting to review operational policy, achievement of targets, patient satisfaction surveys, service improvement and audit results will be held at least annually. The MDT provides appropriate information to referring GPs and other Primary Care Trusts on the appropriate and timeliness of urgent suspected cancers.

Multi-disciplinary team core members should include:

• Designated Breast Surgeon(s)
• Breast Nurse Specialist(s)
• Histopathologist
• Radiologist
• Oncologist(s)
• Multi Disciplinary Team Co-ordinator/Team secretary
• An NHS employed member of the core or extended team should be nominated as having specific responsibility for users’ issues and information for patients and carers
The extended team members should include:

- Palliative Care Specialist/team
- GPs/Primary Care Teams
- Breast Radiographer
- Therapy Radiographer
- Plastic Surgeon
- Psychiatrist/Clinical Psychologist
- Social Worker
- Clinical Geneticist/Genetics Counsellor
- Nominated Orthopaedic Surgeon with expertise in bone metastases as appropriate
- Physiotherapist/Lymphoedema
8.0 Treatment

Surgery

- In the majority of cases pre-operative diagnosis of breast cancer should be confirmed
- Treatment options to be discussed with the patient and recorded in the notes
- All mastectomy patients to be given the opportunity of discussions for reconstruction as clinically appropriate
- Measures to be taken to ensure adequate excision margins. When inadequate further surgery should be considered after discussion at the multi-disciplinary team meeting
- All patients undergoing surgery for invasive cancer should be offered an axillary procedure to establish nodal status
- Surgical treatment trials should be offered to the patient if available or appropriate
- Post operative physiotherapy information or support should be offered for patients undergoing axillary surgery

Radiotherapy

- All radiotherapy should be given with the established regimens of the appropriate radiotherapy centre

Breast Conserving Surgery

- All patients should be considered for radiotherapy

Mastectomy

Radiotherapy to the chest wall should be offered if:
- The invasive tumour is greater than 4cm in diameter
- Resection margins are involved
- 4 or more axillary nodes involved
- Two of the following three:- Grade 3; vascular invasion; 4 or more axillary nodes involved

Radiotherapy to the operated axilla

Axillary radiotherapy should be delivered according to local Trust policy but should be considered if:
- Greater than 4 axillary nodes involved
- Apical nodes involved
- Extracapsular spread evident

Radiotherapy to Supraclavicular Fossa

Radiotherapy to the supraclavicular fossa should be delivered according to local Trust policy but should be considered if:
- More than 4 axillary nodes involved
- Apical node involved
Adjuvant Chemotherapy

The benefits and risks of chemotherapy should be discussed with each patient on an individual basis. Discussions should be based on pathological staging, patient’s age and co-morbidity. Fertility should also be addressed when appropriate.

Adjuvant chemotherapy should be according to the Network Chemotherapy Guidelines and National Institute for Health and Clinical Excellence.

Neo-adjuvant chemotherapy should be discussed on an individual basis at the MDT and administered according to the Network Chemotherapy Guidelines.

Endocrine Therapy

All patients with ER or PR receptor status positivity should be offered endocrine therapy. First line treatment for pre menopausal and peri-menopausal patients is tamoxifen. Neo-adjuvant therapy should be discussed at MDT.

Patients should be considered for entry into clinical trials if possible.

Network Clinical Guidelines detailing Chemotherapy Breast Regimens and Shared Care Guidelines are detailed on the Central South Coast Cancer Network website including:

- Anastrozole for the Adjuvant Treatment of early Breast Cancer
- Exemestane for the Adjuvant Treatment of early Breast Cancer
- Letrozole for the Adjuvant Treatment of early Breast Cancer
- Guidelines for the use of Adjuvant Endocrine Therapy in the Treatment of early Breast Cancer

9.0 Follow up

The Breast NSSG agreed (21.4.09) to adopt the NICE Early and Locally Advanced Breast Cancer guidelines (Feb 2009 pp.24-25), which incorporates follow up imaging and clinical follow up, as outlined below:

The Breast NSSG agreed (21.4.09) to adopt the NICE Early and Locally Advanced Breast Cancer guidelines (Feb 2009 pp.24-25), which incorporates follow up imaging and clinical follow up, as outlined below:

“Follow up Imaging:
1. Offer annual mammography to all patients with early breast cancer, including DCIS, until they enter the NHSBSP/BTWSP. Patients diagnosed with early breast cancer who are already eligible for screening should have annual mammography for 5 years.
2. Do not offer mammography of the ipsilateral soft tissues after mastectomy
3. Do not offer ultrasound or MRI for routine post-treatment surveillance in patients who have been treated for early invasive breast cancer or DCIS

Clinical Follow-up
1. After completion of adjuvant treatment (including chemotherapy, and/or radiotherapy where indicated) for early breast cancer, patients may choose to receive follow up in primary, secondary or shared care.
2. On discharge, patients treated for breast cancer should have an agreed, written care plan, which should be recorded by a named healthcare professional, a copy sent to the GP and a personal copy given to the patient.”

Implementation of the above guidelines has been incorporated in the work programme for the group.

Minimum suggested clinical follow up for invasive cancer:

- Yearly for two years
The mechanism of clinical follow up is at the discretion of individual units, however should be provided by appropriately qualified practitioners.

Facilities for continued clinical follow up should be available for suspected recurrence.

Minimum mammographic follow up for invasive cancer years annually for 5 years as until NHSBSP age.

All patients will receive information and contact details to enable them to access the breast service or to initiate an appointment as required. This may be via the key worker, medical secretary or GP as appropriate.

Follow up may also be triggered by patients who will be provided information regarding how symptoms and how to access ongoing care.

It is anticipated that follow up arrangements will be reviewed as part of the NSSG involvement in the survivorship strategy work.

All patients will receive information and contact details to enable them to access the breast service or to initiate an appointment as required. This may be via the key worker, medical secretary or GP as appropriate.

10.0 Breast cancer recurrence

Any suspected local recurrence should undergo cytological or histological examination where possible for confirmation and be considered for surgical management.

Both local and distant recurrence should be seen by an oncologist.

All patients should have access to psychological and supportive help from Macmillan or other palliative care service.

11.0 Palliative care

Supportive and palliative care should be provided by general and specialist care providers in accordance with the NICE Cancer Service Guidance ‘Improving Supportive and Palliative Care for Adults with Cancer’ which is available from:

http://guidance.nice.org.uk/CSGSP/Guidance/pdf/English

Full guidance around providing ongoing support and care for those with advanced breast cancer can be accessed in the National Institute for Clinical Excellence ‘Advanced Breast Cancer: Diagnosis and Treatment’ (Clinical Guideline 81, February 2009) available from:

http://guidance.nice.org.uk/CG81/Guidance/pdf/English

Patients who have non-operable disease should be referred for palliative treatment. The key principles of palliative care include:

- To provide relief from pain and distressing symptoms
- Integrate the psychological and spiritual aspects of patient care
- Offer a support system to help patients to live as actively as possible
- Be applied early in the course of illness in conjunction with other therapies to prolong life
All patients with breast cancer should have access to the specialist palliative care team who can provide specialist palliative care advice for individual patients and if necessary access to specialist palliative care for in patients, or access support for death at a place of the patient's choice.

Please see Appendices for the Network Specialist Palliative Care Pathway

12.0 Patient information pathway

The patient information pathway has been mapped following the model proposed by the Cancer Collaborative Service 'Improvement Partnership' using the key points in the care pathway. Workshops with the network Breast Nurses Group including patient representatives was held to map the patient information pathway, identify areas of good practice and gaps in the available information. As a result a patient information pathway was developed. This was designed to be used with Wessex Cancer Trust information folder if desired. The patient pathway information and the list of available information for Breast patients was reviewed and discussed by a patient group. These documents can be located on the network website at www.centralsouthcoastcancernetwork.nhs.uk

Information for people with breast cancer, their families and carers, and the public is produced by the National Institute for Health and Clinical Excellence (NICE). The information is available from the Nice website www.nice.org.uk
Central South Coast Cancer Network

Information Flow Chart for patients with breast cancer
A mixture of written and verbal information will be offered to patients and their carers but it must be acknowledged it is their choice whether to accept it

**Screening**
Information sent out with the screening appointment
(available in several languages, Braille and for those with learning disabilities)

**Symptoms**
Health promotion material available from GP services, pharmacies, libraries, media, NHS Direct

**Screening recall**
Information sent out with letter about recall

**GP visit**
Verbal information about the clinic
Reason for referral
About 2 week wait
Where clinic is
May be given appt by GP staff

Information about clinic including which doctor, how to get there, where to park, likely time of visit from hospital either verbal (because appt made by phone) or written information sent by appt department. This may include information on the clinic and likely investigations

**Hospital Appointment**
Introduction by Consultant on purpose of clinic
Written and or verbal information on
- Necessary investigations
- Appointments
- Consent
- Likely timescale of events

**One Stop Clinic** (i.e. given diagnosis that visit)
See overleaf for relevant information

CSCCN Breast Cancer Pathway of Care 2011.4 Revised 27 10 11
Breast cancer information pathway cont

Results
Verbal & written information on
  Disease/further investigations
  Likely treatment options
  Relevant supportive care information as appropriate and if required
Introduction to Key worker/CNS if not already known
Introduction of hand held record if used
New contact details if further treatment is in different hospitals
Signposting to further sources of information both locally and nationally such as information centres, websites, support groups

Treatment
Verbal and/or written discussion about what the proposed treatment option involves including risks and benefits for consent purposes
Consent
Introduction to Key worker/CNS if any change involved
Information about new hospital if need for change
Signposting to further sources of information/support

Follow up/Continuing Care
Information on effectiveness of treatment
Reason for follow up/symptoms to be aware of
Management of short/long term side effects of treatment
Reiterate previous signposting if required
Transfer of key worker if appropriate

Recurrence
Information about
  Investigations
  Treatment options including No active Treatment
  Symptom control
  Accessing clinic
  Signposting to further services such as palliative care, information, benefits advice
  Possible transfer of key worker

Continuing follow up
Information on managing any long term side effects including emotional issues

Death and Bereavement
Information about
  Local services available and how to access them
  Management of symptoms
  Accessing the hospital
  Supportive information
  Bereavement support for the family
## 13.0 Key contacts

### 13.1 Portsmouth Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Clinician</td>
<td>Carmel Sheppard</td>
<td><a href="mailto:carmel.sheppard@porthosp.nhs.uk">carmel.sheppard@porthosp.nhs.uk</a></td>
<td>023 92 762353</td>
</tr>
<tr>
<td>Clinical Nurse Specialist(s)</td>
<td>Rosemary Buck</td>
<td><a href="mailto:rosemary.buck@porthosp.nhs.uk">rosemary.buck@porthosp.nhs.uk</a></td>
<td>023 92 762382</td>
</tr>
<tr>
<td>Breast Care Nurses</td>
<td>Julie Douglas</td>
<td><a href="mailto:julie.douglas@porthosp.nhs.uk">julie.douglas@porthosp.nhs.uk</a></td>
<td>023 92 762926/2382</td>
</tr>
<tr>
<td></td>
<td>Julie Evans</td>
<td><a href="mailto:julie.evans@porthosp.nhs.uk">julie.evans@porthosp.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clare Gladstone</td>
<td><a href="mailto:clare.gladstone@porthosp.nhs.uk">clare.gladstone@porthosp.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clare Atkins</td>
<td><a href="mailto:clare.atkins@porthosp.nhs.uk">clare.atkins@porthosp.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>MDT Co-ordinator</td>
<td>Deborah Lashley</td>
<td><a href="mailto:deborah.lashley@porthosp.nhs.uk">deborah.lashley@porthosp.nhs.uk</a></td>
<td>023 92 762692</td>
</tr>
<tr>
<td>Lead Cancer Manager</td>
<td>Jeremy Whitely</td>
<td><a href="mailto:jeremy.whitely@porthosp.nhs.uk">jeremy.whitely@porthosp.nhs.uk</a></td>
<td>023 92 286000 ext 2458</td>
</tr>
</tbody>
</table>

### 13.2 Southampton University Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Email</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Lead Clinician</td>
<td>Mr Gavin Royle</td>
<td><a href="mailto:gavin.royle@suht.swest.nhs.uk">gavin.royle@suht.swest.nhs.uk</a></td>
<td>023 8079 6676</td>
</tr>
<tr>
<td>Clinical Nurse Specialist(s)</td>
<td>Catherine Walsh</td>
<td><a href="mailto:catherine.walsh@suht.swest.nhs.uk">catherine.walsh@suht.swest.nhs.uk</a></td>
<td>023 8077 7222 Ext 3753</td>
</tr>
<tr>
<td></td>
<td>Emma Bourne</td>
<td><a href="mailto:emma.bourne@suht.swest.nhs.uk">emma.bourne@suht.swest.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kye Squire</td>
<td><a href="mailto:michaela.squire@suht.swest.nhs.uk">michaela.squire@suht.swest.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Caroline Evans</td>
<td><a href="mailto:caroline.evans@suht.swest.nhs.uk">caroline.evans@suht.swest.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>MDT Co-ordinator</td>
<td>Eileen Colella</td>
<td><a href="mailto:Eileen.colella@suht.swest.nhs.uk">Eileen.colella@suht.swest.nhs.uk</a></td>
<td>023 8079 8843</td>
</tr>
<tr>
<td>Lead Cancer Manager</td>
<td>Christine Day</td>
<td><a href="mailto:Christine.day@suht.swest.nhs.uk">Christine.day@suht.swest.nhs.uk</a></td>
<td>023 8079 6636</td>
</tr>
</tbody>
</table>

### 13.3 Isle of Wight Healthcare Primary Care Trust

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Clinician</td>
<td>Mr Richard Sainsbury</td>
<td><a href="mailto:Richard.sainsbury@iow.nhs.uk">Richard.sainsbury@iow.nhs.uk</a></td>
<td>01983 534757</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>Jasmine Light</td>
<td><a href="mailto:jasmine.light@iow.nhs.uk">jasmine.light@iow.nhs.uk</a></td>
<td>01983 534562</td>
</tr>
<tr>
<td>MDT Co-ordinator</td>
<td>Caron French</td>
<td><a href="mailto:caron.french@iow.nhs.uk">caron.french@iow.nhs.uk</a></td>
<td>01983 534176</td>
</tr>
<tr>
<td>Lead Cancer Manager</td>
<td>Liz Warner</td>
<td><a href="mailto:liz.warner@iow.nhs.uk">liz.warner@iow.nhs.uk</a></td>
<td>01983 534442</td>
</tr>
</tbody>
</table>

### 13.4 Winchester and Eastleigh Healthcare NHS Trust

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Clinician</td>
<td>Miss Siobhan Laws</td>
<td><a href="mailto:siobhan.laws@wehct.nhs.uk">siobhan.laws@wehct.nhs.uk</a></td>
<td>01962 825889</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>Lyn Booth and Lorraine Brown</td>
<td><a href="mailto:breastcare.nurses@wehct.nhs.uk">breastcare.nurses@wehct.nhs.uk</a></td>
<td>01962 824592</td>
</tr>
<tr>
<td>MDT Co-ordinator</td>
<td>Virginia Straker</td>
<td><a href="mailto:Virginia.straker@wehct.nhs.uk">Virginia.straker@wehct.nhs.uk</a></td>
<td>01962 825102</td>
</tr>
</tbody>
</table>

### 13.5 Basingstoke & North Hampshire NHS Foundation Trust

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Clinician</td>
<td>Mr Kevin Harris</td>
<td><a href="mailto:Kevin.harris@bnhft.nhs.uk">Kevin.harris@bnhft.nhs.uk</a></td>
<td>01256 314310</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>Anne Bremer</td>
<td><a href="mailto:anne.bremer@bnhft.nhs.uk">anne.bremer@bnhft.nhs.uk</a></td>
<td>01256</td>
</tr>
<tr>
<td></td>
<td>Trish Paterson</td>
<td><a href="mailto:trish.paterson@bnhft.nhs.uk">trish.paterson@bnhft.nhs.uk</a></td>
<td>313123</td>
</tr>
<tr>
<td>MDT Co-ordinator</td>
<td>Dehila Norris</td>
<td><a href="mailto:dehila.norris@bnhft.nhs.uk">dehila.norris@bnhft.nhs.uk</a></td>
<td>01256 314310</td>
</tr>
<tr>
<td>Lead Cancer Manager</td>
<td>Emily Arbuthnot-Smith</td>
<td><a href="mailto:Emily.arbuthnot-smith@bnhft.nhs.uk">Emily.arbuthnot-smith@bnhft.nhs.uk</a></td>
<td>01256 486702</td>
</tr>
</tbody>
</table>
### 13.6 Western Sussex Hospitals Trust (St Richard’s Hospital)

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Clinician</td>
<td>Wendy Sotheran</td>
<td><a href="mailto:Wendy.sotheran@wsht.nhs.uk">Wendy.sotheran@wsht.nhs.uk</a></td>
<td>01243 788122 ext 2711</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>Elaine Thomas</td>
<td><a href="mailto:elaine.thomas@wsht.nhs.uk">elaine.thomas@wsht.nhs.uk</a></td>
<td>01243 788122 ext 3310</td>
</tr>
<tr>
<td>MDT Co-ordinator</td>
<td>Adele Thomas</td>
<td><a href="mailto:adele.thomas@wsht.nhs.uk">adele.thomas@wsht.nhs.uk</a></td>
<td>01243 788122 ext 3255</td>
</tr>
<tr>
<td>Lead Cancer Nurse</td>
<td>Tim Hutson</td>
<td><a href="mailto:tim.hutson@rws-tr.nhs.uk">tim.hutson@rws-tr.nhs.uk</a></td>
<td>01243 788122 ext 2813</td>
</tr>
</tbody>
</table>

### 13.7 Salisbury NHS Foundation Trust

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Clinician</td>
<td>Ms Victoria Brown</td>
<td><a href="mailto:victoria.brown@salisbury.nhs.uk">victoria.brown@salisbury.nhs.uk</a></td>
<td>01722 336262 ext 4989</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>Shirley Holmes</td>
<td><a href="mailto:shirley.holmes@salisbury.nhs.uk">shirley.holmes@salisbury.nhs.uk</a></td>
<td>01722 336262 ext 4475</td>
</tr>
<tr>
<td>Breast Services Manager/MDT Co-ordinator</td>
<td>Sonnya Dabill</td>
<td><a href="mailto:sonnya.dabill@salisbury.nhs.uk">sonnya.dabill@salisbury.nhs.uk</a></td>
<td>01722 336262 ext 4768</td>
</tr>
<tr>
<td>Lead Cancer Manager</td>
<td>Jonathan Wright</td>
<td><a href="mailto:jonathan.wright@salisbury.nhs.uk">jonathan.wright@salisbury.nhs.uk</a></td>
<td>01722 336262 ext 2873</td>
</tr>
</tbody>
</table>
## 14. Appendices

### 14.1 Communication and Referral Protocol (CaRP) – Central South Coast Cancer Network

Inter-Trust Referral form : Communication and Referral Protocol (CaRP)
E-mail the recipient using Outlook that you have sent a fax or you have sent the patient details using the NHS.net.

<table>
<thead>
<tr>
<th>CANCER REFERRAL PRIORITY TYPE</th>
<th>TARGET DATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 URGENT GP (2WW)</td>
<td>62-DAY START DATE</td>
</tr>
<tr>
<td>02 SCREENING REFERRAL</td>
<td>62-DAY TARGET DATE</td>
</tr>
<tr>
<td>03 CONSULTANT UPGRADE</td>
<td>If no priority is indicated, a 31-day target still applies from Decision to Treat (DTT)</td>
</tr>
<tr>
<td>04 SUBSEQUENT TREATMENT</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT DETAILS FROM REFERRING HOSPITAL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SURNAME:</td>
</tr>
<tr>
<td>2. FIRST NAME:</td>
</tr>
<tr>
<td>3. PAS NO:</td>
</tr>
<tr>
<td>4. NHS NO:</td>
</tr>
<tr>
<td>5. D.O.B:</td>
</tr>
<tr>
<td>6. PPI NO:</td>
</tr>
<tr>
<td>7. TELEPHONE:</td>
</tr>
<tr>
<td>8. Consultant/GP (Name/Address/Sp ecialty)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONSULTANT REFERRAL TO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. HOSPITAL:</td>
</tr>
<tr>
<td>10. TRUST CODE:</td>
</tr>
<tr>
<td>11. CONSULTANT NAME:</td>
</tr>
<tr>
<td>12. SPECIALITY:</td>
</tr>
<tr>
<td>13. REFERRAL REASON:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER INFORMATION REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>REFERRAL INFORMATION:</td>
</tr>
<tr>
<td>14. DATE REFERRAL RECEIVED:</td>
</tr>
<tr>
<td>15. DECISION TO REFER DATE:</td>
</tr>
<tr>
<td>16. DATE FIRST SEEN:</td>
</tr>
<tr>
<td>17. ORGANISATION CODE (FIRST SEEN):</td>
</tr>
<tr>
<td>18. DATE OF DNA AT 1ST OP APPT:</td>
</tr>
<tr>
<td>19.</td>
</tr>
<tr>
<td>DIAGNOSIS:</td>
</tr>
<tr>
<td>20. TUMOUR SITE:</td>
</tr>
<tr>
<td>21. PRIMARY DIAGNOSIS (ICD 10):</td>
</tr>
<tr>
<td>22. LATERALITY TUMOUR SITE:</td>
</tr>
<tr>
<td>23. MDT DISCUSSION:</td>
</tr>
<tr>
<td>YES / NO</td>
</tr>
<tr>
<td>24. MDT DISCUSSION DATE:</td>
</tr>
<tr>
<td>25. MDT CONTACT NAME:</td>
</tr>
<tr>
<td>26. OTHER INFORMATION:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REFERRAL AT DAY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAYS LEFT ON 62 DAY PATHWAY</td>
</tr>
<tr>
<td>DATE CARP SENT:</td>
</tr>
</tbody>
</table>

April 2010
14.2 The role of the key worker

This is a summary of the Central South Coast Cancer Network Key Worker Guidance (2007). Please refer to this document for more detailed information regarding the key worker role.

The role of the key worker ensures that all patients with a cancer diagnosis receive continuity of care and high levels of support and communication throughout the care pathway (The Manual for Cancer Services (Department of Health, 2004), Improving Supportive and Palliative Care for Adults Guidance (National Institute for Clinical Excellence (NICE), 2004)).

This is supported by the National Institute for Clinical Guidance on Cancer Services (NICE) Improving Supportive and Palliative Care for Adults with Cancer (2004) which states that, ‘There is good evidence that supports that patients want someone they can contact about their care at any one time’ and that teams may wish to consider nominating (with the agreement of the patient) a person to act as ‘key worker’. The role might involve:

- Orchestrating assessments to ensure patients’ needs are elicited
- Ensuring findings from assessments and care plans are communicated to others involved in a patient’s care
- Ensuring patients know who to contact when help or advice is needed, whether the ‘Key worker’ or other appropriate personnel
- Managing transition of care

Following focus groups with professionals and patients (Key Worker Guidance, Central South Coast Cancer Network, 2007); it is recommended that all patients should have a clearly identified point of contact from referral to provide information, advice and sign-posting to relevant services. At the point of a cancer diagnosis/treatment planning, the MDT will nominate one named person as key worker (with the agreement of the patient), aiming to ensure that the patient receives co-ordinated, clinical continuity of care throughout the patient journey, and providing a clearly recorded contact point for the patient and their family. Additional contacts should also be provided, particularly information for emergency access.

The key worker provides direct access to the Multi-Disciplinary Team, acting as advocate for the patient and their family in discussions about treatment options and ongoing care, and signposting to relevant support and information organisations. The key worker provides emotional support, and assesses when specialised psychological support is required, and refers or signposts as appropriate.

The key worker is the primary source of information for the patient and their family, and offers timely, relevant information having assessed the most appropriate format on an individual basis. Within the role, the key worker will act as an enabler, to support the patient to retain control; offering health options and health promotion, while supporting the patient and their family to plan for the future.

Where transitions of care occur, handover should be discussed with the patient, recorded in case notes, and contact details provided for the patient and their family.

References:

Central South Coast Cancer Network (2007) Network Guidance for Key Worker Role
www.centralsouthcoastcancernetwork.nhs.uk


Outline Points of Patient Pathway demonstrating Key Worker Involvement

Referral

Investigations

Consultation

Diagnosis

Staging/Treatment Plans

Treatment

Ongoing Care (include Active Monitoring)

Palliative Care

Recurrence

Discharge

Point of Contact Provided (GP, admin support)

Point of Contact reviewed (GP, admin support, MDT co-ordinator, CNS)

Key Worker identified in MDT.
Patient informed of full contact details, documented in patient case notes (CNS, Care Tracker)

GP informed.

Ongoing support by Key Worker, close liaison with treatment provider

Key Worker Reviewed in consultation with patient

Point of Contact Provided (GP, admin support)
14.3 Clinical Nurse Specialist Minimum Standards

Generic Minimum Service Standards (MSS) for Site Specific Clinical Nurse Specialists (CNSs) in Cancer Care

These generic minimum service standards (MSS) have been developed to identify the core components of a site specific CNS working as part of a cancer Multi-disciplinary Team. They are based on the patient care pathways and Manual of Cancer Services criteria for a site specific CNS and will involve the CNS undertaking systematic holistic common assessment or reassessment at appropriate stages in the patient pathways or at the patient’s request. The CNS, as care nurse member of the MDT, will be responsible for allocation of the patient’s Key Worker (see Network Key Worker Policy 2007).

1. Pre requisites
   - Registered Nurse
   - Post registration qualification in relevant speciality [see National Manual for Cancer Measures 2004]
   - Advanced Communication Skills training
   - Core member of relevant Multi-disciplinary Team

2. Pre Diagnosis
   Patient seen by CNS if referred by:-
   - Health care worker

3. Diagnosis
   CNS should be available for breaking of bad news/diagnosis. If not physically present, the CNS will ensure the patient is contacted by the end of the following working day (individual NSSG subgroups to agree for their speciality). The patient should be given contact details of the CNS at their diagnosis consultation.

4. Staging
   - Supports individual patient/carer
   - Contributes to timely access to diagnostics to facilitate achievement of cancer targets
   - Liaise with co-ordinator to ensure MDT discussion of patient

5. Treatment
   As a minimum all patients will be offered the following CNS intervention/support:-
   - CNS assessment/consultation prior to treatment and at conclusion of treatment
   - Provision of information (see site specific patient information pathway)
   - Ongoing support to patient/carer depending on individual need
   - Onward referral to other health professionals/other agencies as appropriate on individual need

6. Follow up/Recurrence
   CNS intervention/support will be provided on an individual basis as a result of
   - Patient self referral
   - Health care worker referral
   - CNS assessment
14.4 Holistic Assessment Tool

The network is looking to adopt the “Holistic Assessment of Supportive and Palliative Care needs for Adults with Cancer” (Cancer Action Team, January 2007). This will provide the principles for the single assessment process which is ultimately aimed to be incorporated in the electronic patient record.
14.5 Specialist Palliative Care Pathways

1.0 Acute Hospital Specialist Palliative Care Pathway

Inpatient Pathway

- Patient in hospital identified as having SPC needs
- Referral to AHSPCT for assessment and advice

- Ongoing SPC needs identified (levels 2/3/4)
  - Patient wishes to remain in hospital
    - Telephone advice from AHSPCT – no referral required (level 1)
  - Patient's condition stabilises – fit for discharge from hospital
    - Hospital
  - Further active treatment futile, patient wishes to die at home
    - Inpatient specialist palliative care (hospice) (see pathway)
    - Bereavement support to family/carerers
  - Ongoing SPC needs identified (level 4)
    - Rapid discharge facilitation, in liaison with primary care team -> die at home

Out Patient Pathway

- Patient in outpatients identified as having SPC needs
- Referral to AHSPCT for assessment and advice

- Ongoing SPC needs identified (levels 2/3/4)
  - Patient wishes to remain in hospital
    - Telephone advice from AHSPCT – no referral required (level 1)
  - Patient's condition stabilises – fit for discharge from hospital
    - Hospital
  - Further active treatment futile, patient wishes to die at home
    - Inpatient specialist palliative care (hospice) (see pathway)
    - Bereavement support to family/carerers
  - Ongoing SPC needs identified (level 4)
    - Rapid discharge facilitation, in liaison with primary care team -> die at home

Community Pathway

- Patient already identified as having SPC needs, admitted to acute hospital
- Referral to AHSPCT for assessment and advice

- Short term intervention only (level 2/3)
  - Hospital

- Ongoing SPC needs, agreed with GP, refer to CSPCT for home visit or OP (see community pathway) (level 2/3/4)
  - No further SPC needs identified, discharged from the service, to care of GP (level 2)

Re-referral
Community Specialist Palliative Care Pathway

Re-referral

Patient in Hospice
Ongoing SPC needs identified by hospice MDT

Patient in Community
SPC needs identified by Primary Care Team

Patient in Out Patients
SPC needs identified by CSPCT or AHSPCT

Patient in Hospital
Ongoing SPC needs identified by AHSPCT

Referral to Community Palliative Care Team

Community team first assessment (home visit / OPA)

Hospice admission (Hospice pathway) (level 4)

Ongoing SPC needs identified (level 3/4)

Discharge from palliative care service (level 2)

Acute hospital admission with AHSPCT follow up if necessary (AHSPCT pathway)

Day care follow up (level 4)

No further SPC needs identified (level 3)

Patient dies in community

Discharge from community palliative care services

Bereavement support to family/carers
Inpatient Specialist Palliative Care Pathway

**Key**

**MDT**: Multi-disciplinary team  
**SPC**: Specialist Palliative Care  
**AHSPCT**: Acute Hospital Specialist Palliative Care  
**CSPCT**: Community Palliative Care Team  
**PCT**: Primary Care Team  
Community is defined to include home, nursing home, community hospital, prison etc.

**Levels of Intervention**

**Level 1**: Advice available as one off discussions between professionals  
**Level 2**: Single consultation – if possible joint visit by SPC team and the individuals making the referral  
**Level 3**: SPC team provides advice and support for a short period of time e.g. at diagnosis or death  
**Level 4**: Long term interventions by SPC team due to multiple problems

---

**Patient in the Community**  
Patient identified by PCT or CSPCT as having SPC needs requiring in patient admission

**Patient in Hospital**  
Patient identified by AHSPCT as having SPC needs requiring in patient admission

**Patient in Out Patients**  
Patient identified by CSPCT or AHSPCT as having SPC needs requiring in patient admission

**Re-referral**

**Specialist Palliative Care Inpatient Unit (Hospice)**  
Admission, assessment and management by SPC MDT (level 3/4)

**Acute change in patient’s condition requiring active intervention**

**Hospital**

**Patient’s condition stabilised – fit for discharge to community**

**No further SPC needs identified, discharged from service**

**Patient dies in hospital**

**Patient not admitted**

**Telephone advice from Hospice (level 1)**

**Ongoing SPC needs, refer to CPCT (see pathway) (level 4)**

**Bereavement support to family/carer**

**Patient dies in hospice**
Children and Young People Pathway

**Draft Wessex CYP CH Teenage and Young Adult Cancer Pathway (16-24)**

- **Urgent referral**
  - GP/Screening
  - First seen at local site specific Diagnostic Investigations

- **Cancer diagnosis**
  - Or when highly suspicious
  - Patient informed of possible diagnosis/ joint MDT review and place of care options

- **Review at local site specific MDT**
  - Refer to TYA MDT

- **Communication and administrative processes**
  - TYA MDT referral request form to be completed by local MDT and sent to the central point
  - Communication between Medics and Nurses

- **Site Specific MDT review**

- **TYA MDT review**

**Diagnosis and Treatment plan confirmed**

- Patient choice/joint consultation/place of care
- Patient and carer, Unit Gynaecian
- Decision to Treat, Lead Clinician Identified
- All patients to be offered treatment @ PTC

- **PTC Care – treatment and ongoing care**
- **PTC definitive treatment – then shared care**
- **Local treatment with TYA outreach support 19-24 yr**
- **Local treatment with no TYA outreach support 19-24 yr**

**First definitive treatment**

- **MDT Follow up/further assessment**
- **Subsequent treatments**
  - Within 31 days of first treatment
  - **Follow up**
  - Late effects – in line with Wessex CYPCH Guidelines

**TYA MDT**
- Review Site Specific MDT outcomes, diagnostic reports, psycho-social assessment, patient choice/ place of care

**TYA MDT role**
- The purpose of the TYA MDT referral is to inform the TYA PTC team that a patient or referring clinician may require advice or input from a member of the TYA team. Requested by MDT Co-ordinator

**All patients 16-24 to be referred to PTC for TYA MDT discussion**

**TYA Cancer Care Team contact patient**

**If age ≤19**
- Treatment in age appropriate setting @ PTC
- Patient choice treatment in PTC or local SCU

TYA support and patient assessment information offered at all appropriate stages of the patient pathway. A Cancer Nurse Specialist or Paediatric Cancer Pathway (PCCP) will provide support at this point as part of the pathway.

*TYA MDT: Review Site Specific MDT outcomes, diagnostic reports, psycho-social assessment, patient choice/ place of care.*