National Audit of Breast Cancer in Older Patients (NABCOP)
Clinical Steering Group Meeting

Wednesday 28th February 2018, 11am-1pm
Research Board Room, Royal College of Surgeons of England

MEETING MINUTES[1]

Present:

Kieran Horgan (Chair)	Ashu Gandhi	Ian Kunkler (by TC)
Karen Clements (by TC)	Melissa Gannon	Jibby Medina
David Cromwell	Margot Gosney (by TC)	Stanley Ralph
Marianne Dillon	Lis Grimsey	Sophia Turner
David Dodwell	Eluned Hughes	Maggie Wilcox
Deborah Fenlon	Yasmin Jauhari	

Apologies:

Pat Fairbrother	Tom Robinson	Maggie Wilcox
Jackie Jenkins	Nisha Sharma	Lynda Wyld
Emma Pennery	Richard Simcock	

1. Welcome, introductions and apologies

- The chair welcomed the group to the Clinical Steering Group (CSG) meeting for the National Audit of Breast Cancer in Older Patients (NABCOP). Apologies were given for those unable to attend. IK, MG and KC joined by phone.
- Sophia Turner was welcomed as a patient representative and a new member of the NABCOP CSG.

2. Declaration of any conflict of interest

- DF declared that she has recently done some teaching for ROCHE.

3. Minutes of the last Clinical Steering Group Meeting: 4th October 2017

- The 4th October 2017 meeting minutes were reviewed and accepted as a true and accurate record of the meeting, and there were no actions outstanding.

Action 28/02-01: JM to make one correction to the October 2017 minutes to reflect that the ABS conference is in June (not July) 2018.

4. Matters arising: None at this time.

5. Clinical Steering Group membership

- ST has joined the group as a new patient representative for Independent Cancer Patients' Voice. Pat Fairbrother has also joined the CSG in this capacity but was unable to attend this meeting.
- Jackie Jenkins has agreed to join the CSG but was unable to attend this meeting.
- No changes were made to the Terms of Reference at this time.

6. Project Overview

6.a. Highlights from the past 4 months

- Over the last four months, the project team (PT) have worked closely with NCRAS and NHS Wales Health Collaborative to secure the Cancer Registry datasets for 2014-16 diagnoses, which were received in December 2017.

[1] Confirmed June 2018.

- Analyses of data have been ongoing and the drafting of the annual report has commenced.
- Members of the CSG met with the audit team to provide expert input on the data analysis and the presentation of the results, both to professional and lay audiences.

6.b. Re-cap of subgroups / expert input

(1) The assessing frailty, comorbidities and cognition subgroup meet in December 2017 (minutes and a draft assessment tool – circulated prior to meeting):

- KH highlighted the challenges of understanding the variation in the type and amount of treatment that is given to patients and within patient context, what information the audit has about co-morbidity, cognition and level of frailty. The subgroup met and exchanged ideas around how to effectively measure this information on older patients within breast clinics, making the scoring available at MDT. This was successful and a draft tool was created.
- In response to IK query about the validation of the frailty tool, KH confirmed that the subgroups found them to be well validated and have plans to pilot the tool in a variety of centres.
- MGos provided some information on the Abbreviated Mental Health Score (AMHS) validity in primary care and screening, stating that it is well established but poorly validated.
- AG enquired as to how the tool will be used by the MDT and how it will be used on a practical basis. KH stated that as of yet, without sufficient information for the MDT (provided from using the tool), they do not know what best care should look like.
- AG suggested the use of a framework during the piloting stage providing guidance on scores e.g. score X would be treated with Y. KH suggested that after collecting information from the pilot, the audit will be able to produce a framework. JM felt that it will therefore be important to have sufficient records of treatments linked to scores.
- IK questioned how long it takes to collect the items on draft frailty scale, who would be collecting them and whether any training needs to be provided before the pilot study commences. KH hopes to discover these points during the pilot stage.

(2) The Data analyses inclusion & exclusion criteria subgroup met in early February 2018:

- A document describing the principles of the audit analyses, including inclusion and exclusion criteria, has been created. This technical document has not been circulated to the CSG, but is available upon request to any member who wishes to see it (please contact JM about this).

(3) The Presentation of results subgroup met in late February 2018 (document – circulated prior to meeting).

- This last subgroup meeting focused on the presentation of results in the main report, the public/patient version of the report, and the website. The useful characteristics of infographics were also discussed based on previous examples. There was a preference for simple infographics, which contained meaningful rather than "cartoon" graphical representations. Including recommendations was also thought valuable.

Action 28/02-02: The CSG was invited to share any ideas about infographics that would be useful to use in presenting this year's audit results. Please email JM with your suggestions.

6.c. Timeline to publication (Project Timeline circulated prior to meeting).

- All patient-level clinical data has been received for England and Wales, and a first draft is to be shared with HQIP and the CSG on the 28 March 2018. A deadline will be set for feedback, with a view to producing the 2nd draft of the report in the run up to its publication on the 18 June 2018.
- IK suggested this may be a good time to flag trusts that have collected high levels of data as a way to spread good practice.

Action 28/02-03: KH suggested sending congratulatory messages to Trusts that have collected high levels of data as a way to spread good practice, and IK proposed making a public publication of top 10 trusts across the country. The PT will consider these suggestions and propose the best way to take this forward.

6.d. Collaborations: GIRFT and CQC.

- The project is collaborating with the Breast Surgery component of Getting It Right First Time (GIRFT). They will be including NABCOP's Organisational Survey data in their first report.
- A meeting with the CQC has taken place and it has been agreed that NABCOP will share their proposed indicators, once set. The CQC will introduce the NABCOP team to a colleague conducting a thematic analysis using data from NCRAS.

7. 2018 Annual Report

7.a. Analyses of patient data – Data Quality and Indicators.

- N.B. NCRAS are yet to produce their patient experience data, so this will not be included in the 2018 annual report.
- Tumour characteristics (Slide 17): MGos highlighted that the older the patient the more likely they are to fall into the 'no stage' group and asked: were these woman unstageable or just not staged due to their age? MD suggested the lack of staging in older patients may be because they are not having surgery.
- Triple diagnostic assessment (TDA) in a single visit (Slide 22): KH clarified TDA as gold standard for breast cancer diagnosis; on the first visit, the patient should have a history & physical examination, appropriate imaging (ultrasound and mammography) and any necessary needle biopsy all carried out. It appears either NHS breast units are not delivering TDA within a single visit in all women, regardless of age, of if they are, it is not being accurately recorded. MD stated that, often small groups of clinicians within a centre influence the ability to do all 3 parts of the assessment in one day, eg. a surgeon delaying assessment can prevent a radiology appointment. IK asked the group whether the TDA results presented across Trusts accurately reflect individuals own practise. KH reported, following MDs statement, that the number of TDAs in a single visit is diminishing yearly. Referrals are increasing and clinics cannot cope with breast imaging demands whilst striving to meet the 14 day referral schedule. MGos suggested to add 75+ group as a comparison; MG agreed this could be looked at.
- Referral Route: AG suggested we compare findings to screening numbers for UK (vs our graphs). MG to email AG with Qs on this.
- Hormone status: Specifically ER and HER2 status. IK showed some concern for the missing ER reporting in the submitted data. MD suggested a benchmark should be set when recording ER and HER2, with the NICE recommendation being 100%.
- CNS: The data showed a drop off in completeness during 2015. LG suggested that within Somerset, the CNS are so pushed for time that entering this data is seen as a low priority. The CNS are seeing patients but not uploading to the database. IK commented that when the CNS begin using the drafted assessment tool, it will be vital that this information is added to the database. LG flagged that, within Somerset, there have been some systematic errors when recording data. KC highlighted issues with data completeness have been flagged with NCRAS; they are currently exploring the explanation for the sudden drop and will be working with the data liaison teams to feed back to all the Trusts. KH asked that data items needing early action are clearly prioritised.
- Time to First Treatment: Most women start treatment (surgery, chemotherapy) within 2-8 weeks of diagnosis. MD suggested the size of the unit could be included in the data reporting; MG stated that this could be a possibility. IK noted that the short timings should be positively celebrated rather than highlighting units short falls. MD commented that it may be beneficial to marry these results up with who has triple assessment; if a patient has all three assessments in one days, does this determine a lesser time until treatment?
- Surgical Indicators: The results appeared as expected. MD noted that the figures broken into 5 years age groups were more effective. KH and IK returned to the consideration of the frailty assessment tool pilot – KH clarified that the pilot will focus on the ease of completion and its intervention with PT pathway and clinical flow. IK suggested that funnel plots should be carefully explained if included within the report.
- Axillary Nodal Surgery: This was a work in progress and YJ highlighted the need to account for tumour size and so a graph to compare just T1/T2 tumours to tumour size would be beneficial.

- Chemotherapy and Radiotherapy: MD suggested adding the numbers for each grouping and DF also mentioned the addition of hormone receptor status as there may be more older people receiving non-surgical treatments based on their hormone receptor status.
- Inclusion of small Trusts: AG suggested to not include Christie and Clatterbridge as not primary diagnosis centres. DF was surprised by the small numbers for Croydon; suggested this may results from patients being seen at the Royal Marsden. AG felt that Southport and Liverpool should be amalgamated into one trust. There was agreement to explore the re-organisation of services but questions around the 3 years data cut off period. KH agreed that presentation should focus on units with 100 patients or greater, units with less are to not be included in the report. The group are to flag up any slides that would be of most interest and email these to Jibby in order to put more emphasis on this when coming to the report

Action 28/02-04: The project team are to take on board all feedback provided by the CSG on the presentation of data quality, and the findings in relation to the NABCOP Indicators, when producing the 1st draft of the NABCOP 2018 Annual Report to be sent to HQIP/the commissioner on the 28 March 2018.

7.b. Drafting of Annual Report

- JM updated the CSG on the timeline (circulated prior to the meeting) to publishing the NABCOP 2018 Annual Report. Key dates to bear in mind: The draft of the NABCOP 2018 Annual Report is to be sent to HQIP/the commissioner on the 28 March 2018. The final report (incorporating feedback from the CSG) is due to be sent to HQIP in May 2018, in preparation for publication in June 2018.

Action 28/02-05: JM will send the CSG a copy of the 1st draft of the NABCOP 2018 Annual Report on the 28 March 2018, and provide a deadline for feedback from the CSG.

8. Any other business: None.

9. Date of next meeting

- Monday 11 June 2018 11:00-13:00 at the Royal College of Surgeons of England.

Action 28/02-06: Copies of the final 2018 Annual Report (due for publication on 18 June 2018) will be made available at this meeting.

Actions from Clinical Steering Group meeting: 28 February 2018	Owner	Due Date
Action 28/02-01: JM to make one correction to the October 2017 minutes to reflect that the ABS conference is in June (not July) 2018.	JM	28/04/18
Action 28/02-02: The CSG was invited to share any ideas about infographics that would be useful to use in presenting this year's audit results. Please email JM with your suggestions.	CSG	13/04/18
Action 28/02-03: KH suggested sending congratulatory messages to Trusts that have collected high levels of data as a way to spread good practice, and IK proposed making a public publication of top 10 trusts across the country. The PT will consider these suggestions and propose the best way to take this forward.	Project Team	18/06/18
Action 28/02-04: The project team are to take on board all feedback provided by the CSG on the presentation of data quality, and the findings in relation to the NABCOP Indicators, when producing the 1st draft of the NABCOP 2018 Annual Report to be sent to HQIP/the commissioner on the 28 March 2018.	Project Team	28/03/18
Action 28/02-05: JM will send the CSG a copy of the 1st draft of the NABCOP 2018 Annual Report on the 28 March 2018, and provide a deadline for feedback from the CSG.	JM	28/03/18
Action 28/02-06: Copies of the final 2018 Annual Report (due for publication on 18 June 2018) will be made available at this meeting.	CF	11/06/18