Manchester Cancer

Lung Pathway Board – Minutes of meeting

13th January, Humphrey Booth Lecture Theatre 1, Mayo building, SRFT

Attendance	**Representation**
Neil Bayman	Pathway Director
Carol Diver	Tameside
Durgesh Rana	CMFT
Ben Taylor	Christie
Carolyn Allen	Pennine
Simon Bailey	CMFT
Paul O'Donnell	Pennine
Duncan Fullerton	MCHT
Lorraine Creech	Mesothelioma
Apologies	
Coral Higgins	Manchester CCG
Hodan Noor	Manchester Cancer Pathway Manager
Yvonne Summers	Christie
Ian Watson	Oldham CCG/GP
Liam Hosie	Wigan CCG/GP
Karen Clayton	East Cheshire
Simon Taggart	Salford
Rajesh Shah	UHSM
Carol Farran	Stockport
Leena Joseph	UHSM
Christine Eckersley	Bolton
Phil Barber	UHSM
Sriram Iyer	ECHT
Richard Booton	UHSM
Fiona Blackhall	Christie
Ram Sundar	WWL
Jonathan Turnbullross	Manchester Cancer User Involvement Manager

In Attendance:
Jayne Holme, UHSM
Jo Gallagher (representing ECHT), ECHT
Helen Doran (representing histopathology), UHSM
Vee Sibanda (representing WWL), WWL

	AGENDA ITEM	ACTION
1	**Apologies:** Apologies have been noted.	
2	**Minutes from the last meeting** Corrections on misspelling Coral's name; correction on point 3 should state "standardised" pathway not "standard". The rest of the minutes where agreed as an accurate reflection of the last meeting.	
3	**Matters arising** a. Mesothelioma specialist MDT Members received outline information on the case for Mesothelioma regional MDT to agree in principle. JH explained the current UHSM led mesothelioma MDT model and proposal for regional MDT model with patients referred from across GM via an electronic portal. LC explained the focus is to discuss new patients but also additional lines of treatment,clinical trials and post-treatment planning. The board support the case for a regional MDT with an electronic referral system and a rapid feedback. There is a need for financial support. An administrator post is currently being advertised and should be in post in three months. An online portal is in development. Board agreed users should be consulted on usability of portal Acknowledged that CWP is being piloted as an electronic referral to lung MDT. This is part of a wider programme to roll out CWP to all GM MDTs in time. Could be significant delay until CWP could be developed for regional meso MDT. Board agreed that current electronic referral solution should be developed. Acknowledged with pathology standards required for meso alongside those being developed by pathology subgroup for lung cancer Members support the proposal for Meso regional MDT. b. Guidelines NB thanked members who have submitted sections they volunteered for, if members could share all the draft versions by the end of January HN can then collate to one document. CA can complete radiological staging with POD assisting with the non-radiology staging section.	**JH to share the meso referral portal with members for comments** **NB to highlight to Pathology sub group need to develop Meso standards.** **HN to send reminders regarding guidelines**
4	**Greater Manchester Cancer Vanguard (for information)** The aim of the vanguard is to significantly improve the cancer outcomes for the 3.2 million Greater Manchester and Cheshire population. This means work will need to be focussed on prevention and earlier detection in particular, but also on ensuring the highest quality care is offered to all in a coordinated, equitable and responsive way. Specific city-wide projects will be rapidly developed and implemented which will include (i) increasing public awareness of beneficial lifestyle changes and suspected cancer symptoms (both vague and specific symptoms), (ii) Develop streamlined one-stop diagnostic clinics and pilot patient self-referral and (iii) Develop a comprehensive data and intelligence unit related to cancer outcomes and patient experience which will be widely shared amongst healthcare professionals and the public. We aim to reduce referral to treatment for cancer to under a month, from the current 2 months.	 greater_manchester_ cancer_vanguard_initi

	The vanguard is an alliance of partners working together. It creates a single system leader, The Christie, which will be held accountable by commissioners for all cancer outcomes across the city, and be responsible for leading a coordinated approach across all agencies involved in cancer care, spanning the entire spectrum of cancer care from public health and primary care through to diagnostics, treatment, long term support and end of life care. It will seek to ensure consistency, equity and compliance in all cancer services across the conurbation and will establish rigorous co-produced standard setting, and monitoring, to secure this. The overall programme is a 3 year pilot (2015/16 – 2018/19). This Single Cancer Commissioning function means a change to the current model of commissioning responsibility which currently spans 12 CCGs (and East Cheshire) , 10 Local Authorities and NHS England, and will be streamlined through a single cancer commissioner and it is this commissioner who will hold the system leader to account for delivery. A detailed brief is attached for further information.	
5	**Objective no 4 – Improving & standardising high quality care across the whole service** a) Defining optimal MC Lung Cancer pathway – discussion NB shared with members a proposal for a MC Lung Cancer Referral to Decision to Treat Pathway based on NHS England optimal lung cancer pathway and the MC aspiration for a 10-day diagnostic pathway from workshops at the previous board meeting. NB presented a sector-based proposal for implementation of the pathway derived from written feedback following the board meeting on 30th November demonstrating support for a sector-based approach to one-stop rapid diagnostics. It is based on the 3 Trusts (or hospitals - Pennine) within each sector pooling resources and working together to provide a daily single lung cancer service via a 1-stop lung cancer unit. The 4 key features are: i) GP direct access to CT ii) Daily triage of CTs including direct referral to PETCT as appropriate (with report available in 72 hours - PETCT group believe this is achievable and keen to work with us) iii) One-stop new patient clinic and diagnostic bundle (results available within 3 days) at sector-based lung cancer unit iv) One-stop results clinic and treatment decision clinic (surgery/oncology/palliative care) at sector-based lung cancer unit. NB explained GM Cancer Vanguard support and are very keen to prioritise this model. This would help with the complex commissioning arrangements resulting from collaborative working, and access to financial support from the Vanguard transformation fund Query raised whether 72 hours from test to results is calendar or working days. Confirmed these are working days (in line with NHS England pathway) and will include weekends once 7-day working implemented. Query raised on where sector MDT fits. To be determined, but an option would be to hold SMDT shortly after treatment decision clinic, whereby treating clinician's will have already	**NB proposed summary of the discussion and seek members feedback who have not attended to contribute**

seen patient. This might allow a more informed debate on the more complex cases.

A Liverpool pathway was discussed following a recent visit by the team to MCFT and their model of requesting all diagnostics up front following direct-access CT and a telephone interview with a lung cancer CNS. In this model, the patient has had all investigations by time of first appointment in lung cancer clinic. There was concern raised by the CNSs for this approach, particularly the difficulties of a CNS led phone interview.

There was support for the principle of direct access to CT from primary care, although concern was raised regarding current radiology capacity. NB confirmed that this step is directly in-line with recommendations from NHS England.

It was acknowledged that this model with triaging of CT prior to a lung cancer clinic should effectively end the current HSE referral system which creates a real challenge on capacity for some Trusts.

CA asked about PET CT procurement. BT confirmed this will take place in April 2017. PO stated that having a very rapid PETCT service is what matters and location of the scanner when resource scarce across GM less important. BT confirmed there will be an expansion of PET CT activity within the next 5 years as such this would not be a concern.

NB suggested a discussion on the options available (1) keep things as they are aiming to grow services at the individual hospitals, or (2) implementing a rapid diagnostic pathway, via either a sector model as presented today, a single centre stage 1-3/local stage 4 model as presented at the previous meeting, or an alternative. Members agreed doing nothing is not an option however a view was expressed that there should be an evolution stage change approach rather than a big bang.

PO proposed members should agree to support the 10-day diagnostic pathway. From Pennine perspective the sector model will be possible to deliver using the lung unit model. SB also stated this model is possible in the sectors.

CNS capacity was raised as a concern however this could be an opportunity to explore possible gaps to gain some further resources. PD argued demand on CNS at diagnostic step would be reduced using this model as fewer non-cancers would be referred into the clinics.

Query raised on how patients will view proposals, particularly around travel and loss of “personal” local experience. Need to recognise responsive hospital transport is a real gap and need for patients.

Patient consultation is needed and NB confirmed this would of course have to go through a patient consultation process. NB also confirmed user-involvement team have identified two potential PABC representatives, so the board should have at least one PABC representative soon.

DF raised concern about capacity to deliver service, particularly radiology, PET CT, oncology and surgery. NB confirmed a capacity/demand analysis would be required supported by Vanguard. PO stressed there is a need to engage with change to shape future services now or change will be forced to rationalise resources.

	PO commented there is a need for treatment pathway to improve, particularly surgical pathway. SB commented that the sector model will enable a rapid consultations with treating clinicians. Currently, the treatment pathway is slowed by a delay seeing the treating clinicians in separate appointments. DR queried what impact a single centralised service (for stage 1-3 disease) would have on services such as ROSE and whether this would be dismantled. NB noted that the proposal would be to bring these practices into the centre. HD stated that a single centralised service at UHSM would improve quality of pathology service by concentrating expertise. DF agreed sectorised services would be beneficial however there is an opportunity for UHSM and Christie to do more on the treatment pathway. NB confirmed work currently underway to reduce time to radical radiotherapy by two weeks. Reducing time to chemotherapy is capacity dependant and requires devolution of more lung cancer chemotherapy out of Christie main site VS, CA, LC, JH, BT, CD agreed that the sector lung unit model would be possible and would benefit patients with a rapid pathway although it was acknowledged that this was not the view of other UHSM members not present today, that CNS capacity would need to increase to meet the demands of the proposed pathway, and patient travel needs to be considered. It was also acknowledged that wider, further reaching discussions are required due to the impact these proposals could have on services within provider trusts. SB stated that the proposed pathway and sectorised approach to implementation is a good model and really exciting opportunity to deliver better care. It was acknowledged that all pathway board members should have the opportunity to comment, and that this would have to be via email over the next week. A survey will also be sent to sector teams to explore challenges faced as clinicians delivering care with regards to decision making and organisation support to provide solutions. An email detailing this to go out in the next few weeks. Treatment pathway analysis underway HN requested NHS numbers of the original patients for an audit to be undertaken to explore the steps taken.	
6	**Objective no 1 – Improving outcomes / survival rates.** a. MCIP & Screening pilot- evaluation of bid for provider for lung health check and ct scan complete. Still aiming for Apr start to invite patients from pilot GP practices. Operational group established. Locations for LHC and CT scan being sorted. b. ACE projects- No update received c. EBUS Subgroup – no update received	
7	**Objective no 2 – Improving the patient experience** a. Manchester Lung Cancer Patient experience survey Pilot has recently started in central sector. b. Wellbeing event pilot Innovation fund- The first event took place in November with only	

	one quarter of those invited attending. Those who did attend rated the day very well, enjoyed it and said they had learned from it. The event was split over 2 half days but this was too much work for the CNSs and the next event planned for March will be condensed into one day. Some of the sessions may run concurrently so that patients can chose which one they attend so that it is relevant for them.	
8	**Objective no 3 – Research and clinical innovation** Manchester Cancer Lung Trial portfolio	
9	**AOB** **-** Education Event 2016 18th March 2016 – 40 people registered to date. The link is on event brite. Invitations have gone out and the link is on the website. - HN will be working as the PET CT Scan Education Programme Manager for the School of Oncology from the 1st of March a new Pathway Manager will be recruited to support the pathway work. NB thanked HN for all her support. - Oncology sector base reconfiguration (for information)	
10	**Future meetings:** Wednesday, 23 March 2016 , 14:00 until 16:00 Room 6 Christie HQ, Department 2 level 3 Wednesday, 22 June 2016 , 14:00 until 16:00 Room 6 Christie HQ, Department 2 level 3 Friday, 14 October 2016, 14:00 until 16:00 Room 6 Christie HQ, Department 2 level 3	