Manchester Cancer

# Acute Oncology Pathway Board

## Annual Report 2013/14

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**Version 1.0**

## Executive summary

Since the establishment of Manchester Cancer Acute Oncology Pathway Board in January 2014 progress has been made in the co-ordination and delivery of acute oncology services within the region.

- The pathway board has been expanded to include representatives from relevant associated stakeholders who have direct involvement with acute oncology services – these include acute medicine, emergency medicine, palliative medicine and primary care.
- In addition to the core pathway board sub-groups have been established to focus service development and education in specific areas (CUP, MSCC, Education, Nurses Forum) – the groups have themselves held meetings and established membership for their specific remit.
- By increasing the awareness of the Provider Board to the challenges faced by acute oncology services progress has been made in relation to the development of acute oncology services within trusts and the agreement of funding to permit the appointment of non-surgical oncologists to acute oncology posts. Since January the following trusts have agreed/appointed posts:
    - Wigan, Wrightington and Leigh NHS Foundation Trust
    - Bolton NHS Foundation Trust
    - Tameside NHS Foundation Trust
    - Mid-Cheshire NHS Foundation Trust
    - Pennine Acute NHS Foundation Trust.

There continue to be several considerable challenges being faced by acute oncology services within the region. These include:

- The on-going funding of “network services” currently based at The Christie NHS Foundation Trust incorporating access to the patient advice hotline, MSCC co-ordinator, 24 hour health professional oncology advice and access to the Christie clinical portal (electronic patient notes) which all trusts are required to have access to for peer review compliance.
- On-going recurrent funding for acute oncology nurse specialist and non-surgical oncologist posts. Several trusts have agreed to provide on-going funding for posts whilst some trusts have gained funding from CCG’s.
- The on-going development of clinical services within trusts with the aim of achieving full peer review compliance.
- The co-ordination of clinical pathways within the region with agreement on management of acute oncology presentations – namely neutropenic sepsis guidelines.

- The future expansion of acute oncology services to provide improved patient access to services and improved community support for primary care and community based specialities.

Progress has been made in overcoming these challenges through collaborations between members of the acute oncology pathway board and service providers. Support from the provider board will be required in order to resolve the challenges faced in relation to funding of services and the need to negotiate with the clinical commissioning boards to agree funding sources for the network services and acute oncology services within trusts.

The aim of the Acute Oncology pathway group is to ensure that all patients in the Greater Manchester and Cheshire area have equitable access to safe, patient centred, high quality and efficient services in line with the recommendations of the NICE clinical guidelines and National Cancer Action Team (NCAT) measures. The group hopes to expand its current role and services so that it the region becomes a leading centre for acute oncology service provision.

## Introduction

2013/14 was a transitional year for cancer services in Greater Manchester and East Cheshire. 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. They spent the first months in post forming their Pathway Boards, multi-professional clinical groups from across the region. These pathway Boards are now formed and most had their first meeting in April/May of 2014.

As such, this is a transitional annual report. It outlines the current configuration of services, the progress in forming the Pathway Board, the data on outcomes and experience that the Board took into account when setting its objectives, and what those objectives are for 2014/15 and beyond. In July 2015 every Manchester Cancer Pathway Board will publish a full annual report, outlining the work of its first full year and its progress against those objectives.

This annual report is designed to:

- Provide a summary of the work programme, outcomes and progress of the Board – alongside the minutes of its meetings, its action plan and it scorecard it is the key document for the Board.
- Provide an overview to the hospital trust CEOs and other interested parties about the current situation across Manchester Cancer in this particular cancer area
- Meet the requirements of the National Cancer Peer Review Programme
- Be openly published on the external facing website.

## 1. General overview

A report from the National Chemotherapy Advisory Group (NCAG) in August 2009 highlighted that the use of chemotherapy has expanded markedly in recent years, with an increase of around 60 per cent in the amount of chemotherapy delivered over a four year period. Chemotherapy has brought undoubted benefits to many thousands of patients. The National Chemotherapy Action Group (NCAG), guided partly by reports from NCEPOD and NPSA and from previous cancer peer review results, has recommended that a more systematic approach should be taken to dealing with cancer-related emergencies. These recommendations have been embodied in the concept of the 'Acute Oncology Service '. However, the three reports below identified serious concerns about the quality and safety of service delivery, therefore the focus of the NCAG report in 2009 was entirely on safety and quality:

• The national overview of the peer review appraisals undertaken between

2004 and 2007 showed that only around one half of chemotherapy services had cancer network-wide lists of agreed acceptable regimens and guidelines/protocols for chemotherapy service delivery.
• The National Patient Safety Agency (NPSA) issued a Rapid Response Alert in 2008 on oral chemotherapy following a significant number of safety incidents.
• The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) analysed the care given to patients who received systemic anticancer therapy in June and July 2006 and who died within 30 days of treatment.

In April 2011 following a period of consultation the National Cancer Action Team, DH, published national quality measures for acute oncology services. The current peer review measures for 2014 can be found on the CQuINS web-site www.cquins.nhs.uk. The Acute Oncology measures reflect the recommendations of the National Chemotherapy Advisory Group (NCAG) report. Although the NHS is not mandated to adhere to the national quality measures, these measures are used by the National Cancer Peer Review Programme as part of the assessment of cancer services and to provide a ready specification for commissioning of cancer services within a given locality. The quality measures identify the characteristics of service that are likely to have a significant impact on health outcomes and provide assurance of service quality.

Within NHS England's Cancer: Chemotherapy (adult) service specification B15/s/a the requirement to provide 24 hour access to advice and care for patients and health professionals is further defined.

National expectation is that the following types of patients should be seen by an Acute Oncology Team:

- *Those with treatment complications and cancer emergencies;*
- *Those with new or suspected cancer diagnosis (elective and non elective)*
- *Those with cancer of unknown primary site ; and*
- *Those with metastatic spinal cord compression*

Around 25% of newly diagnosed cancer patients first present as an emergency admission, this equates to 3,750 per annum across all acute Trusts in the Network. Greater Manchester incorporating East and Mid Cheshire has over 36,000 emergency admissions of patients with a past or present cancer diagnosis each year. Those who are on active treatment would especially require specialist input as they have a high morbidity and mortality if not managed appropriately. However, most cancer emergency admissions (around 75%) remain under the care of medical and surgical specialties – not oncology and haematology. There is evidence of significant variation as to how such a patient in the acute setting is managed – both 'in hours' and also 'out of hours' – and that such variation in care has a significant impact on outcomes as well as the patient experience. National modeling has evidence that 30% of emergency admissions could be managed by other solutions and 25% could have a shorter stay.

The aim of the Acute Oncology teams is to ensure that all patients in Greater Manchester and Cheshire have equitable access to safe, patient centered, high quality and efficient acute oncology services in line with national recommendations. The development of Acute Oncology Services across the region will make a significant contribution to acutely ill cancer patients. It is a key development to enable hospital Trusts to cope with the growing numbers of patients diagnosed with cancer.

The NCAG (2009) report makes the following key recommendations in relation to acute oncology service development:

- Acute Oncology Services should be established in every Trust with an A&E, ideally by 2011 and that Specialist Cancer Hospitals without an A&E should also have an acute oncology team
- All patients should have access to 24-hour telephone advice with active management of access to appropriate emergency care.
- Patients should know which hospital/unit to go to should they develop complications within or outside normal working hours. AOSs should have clear and readily accessible policies for managing complications including neutropenic sepsis.
- Delivery of antibiotics should occur within one hour ("door to needle" time) of patients presenting with neutropenic sepsis.
- There should be 24-hour access to telephone advice from a consultant oncologist.
- On call staff and receiving staff in A&E and Medical/Emergency Admissions wards should have quick and easy access to information about patient's condition/treatment – in order to provide appropriate emergency care.
- All provider organisations collecting a full dataset for chemotherapy services so that routine audit can be carried out of emergency admissions of patients with cancer treatment related complications
- Governance arrangements need to be established around good documentation and sharing of information across organisations.

## 2. Background to the pathway/cross-cutting area

The GMCCN Programme Board identified Chemotherapy Reform as a priority programme, and established a Chemotherapy Programme Board. A key project within this complex programme of work was the acute oncology project.

In March 2010 an Acute Oncology Project Steering Group was established to design the acute oncology model and options for delivery. The Acute Oncology Project Steering Group (design phase) was multi professional and multi organisational. The Acute Oncology Proposal "Proposed Acute Oncology models for the GMCCN" in Feb 2011 was approved through the Cancer Network's internal governance process and endorsed by the Chemotherapy Programme board, the Greater Manchester and Cheshire Cancer Commissioning Group and the Cancer Network Programme board.

During April/ May 2011 the Acute Oncology Proposal and a proposal to use non- recurring cancer funding as transitional payment to develop acute oncology services was presented to the Greater Manchester PCT: Directors of Commissioning; Directors of Public Health; Directors of Finance and PEC chairs. The feedback was that support for further progress would be subject to clarification of a number of issues.

In June/July 2011 a revised paper clarifying issues raised was taken through the Greater Manchester PCT governance process, including the Greater Manchester Commissioning Programme Board (GMCPB) and the Central and Eastern Cheshire PCT governance process, this paper was endorsed by all the above. In addition GMCCN received written confirmation from all acute providers confirming no liability to the Network or commissioners once non – recurring cancer funding had been used.

Between July and September 2011 officers from the GMCCN met with all localities to identify each localities aspirations and intentions to take forward the development of the Acute Oncology services (AOS).

In October 2011, GMCCN established the AOS requirements of all the localities and associated costs. The level of under spend available to fund AOS was confirmed in November 2011. An offer of 1 year non-recurrent funding was offered to each locality for the development of an acute oncology team in each acute trust.

In November 2011 a network wide Acute Oncology Implementation and Planning group (AOIPG) was established, which transitioned into the network Acute Oncology Cross Cutting Group in September 2012.

From November 2011 GMCCN focussed on the implementation of the Network -wide AO strategy to ensure development of Acute Oncology Teams (initially Nurse & MDT Co-ordinator posts) within each of the 10 Acute Trusts (14 hospital sites with an A&E department) across the Greater Manchester & Cheshire Cancer Network. The AOIPG has also had responsibility for the development of education and training programme for acute oncology, clinical guidelines and pathways, key performance indicators and outcome measures, a minimum dataset and service specification.

The final Acute Oncology NSSG was held on 4th December 2013 and was chaired by Dr Yvonne Summers Consultant Medical Oncologist. The work plan at the end of the group's closure for the year 2012/2013 is attached (appendix 1). The network board was successful in commencing the establishment of acute oncology services in the majority of the trusts within the network however several trusts did not have services which fulfilled compliance with national peer review measures.

The key successes of the group were:

- The implementation of a network wide AO strategy with teams consisting of acute oncology nurses plus administrative support being established in 10 trusts.
- Establishing an acute oncology education and protocol development group to develop clinical guidelines
- Establishing a network MSCC co-ordinator post  plus an MSCC sub-group
- Establishing a network CUP NSSG

The key challenges for the group were:

- Agreement of recurrent funding for NSO posts within acute oncology teams to enable full peer review compliance
- Agreement of recurrent funding for provision of network wide services namely AOMS (acute oncology management service based at The Christie NHS Trust incorporating the Christie hotline, MSCC co-ordinator, Christie clinical portal and provision of 24 hour oncology advice).

Since the establishment of the acute oncology pathway board in January 2014 there has been focused commitment to bring about improvement in the provision of acute oncology services within acute trusts.

## 3. Configuration of services

All ten acute trusts within Manchester cancer plus the Christie NHS Trust currently have active acute oncology services based within them. The configurations of the services within the trusts have been developed according to local needs and resources with the aim being full compliance with current peer review measures.

Manchester Cancer incorporates the following trusts:

Royal Bolton Hospital NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust (Trafford Division)
Christie Hospital NHS Foundation Trust
East Cheshire NHS Trust
Mid Cheshire NHS Foundation Trust
Pennine Acute Hospitals NHS Trust (Bury, North Manchester, Oldham, Rochdale)
Salford Royal Hospital NHS Foundation Trust
Stockport NHS Foundation Trust
Tameside NHS Foundation Trust
University Hospital of South Manchester NHS Foundation Trust
Wrightington Wigan and Leigh NHS Foundation Trust

At present the current status of the acute oncology teams in acute trusts is shown below with some NSO's posts having funding agreed but are awaiting appointment:

| Trust | Non Surgical Oncologist (NSO) Clinical PA's | AONS in post | MDT Coordinator support |
|---|---|---|---|
| Bolton | 5 (to be appointed) | 2 | Present |
| CMFT | 4 | 1 | Present |
| East Cheshire | 4 | 1 | Present |
| PAHT | 9 (to be appointed) | 3 | Present |
| Salford | 5 | 2 | Present |
| UHSM | 3 | 1 | Present |
| Stockport | 5 | 1 | Present |
| Tameside | 5 (to be appointed) | 1 | Present |
| Wigan, Wrightington and Leigh | 6 (to be appointed) | 2 | Present |
| Mid - Cheshire | 1.5 | 2 | Present |

The aim of the services is to achieve full peer review compliance in accordance with National Peer review measures; the current compliance for each of the trusts for the year 2013/2014 is:

| Trust | Acute Oncology MDT measures | General Acute Oncology MDT measures | Acute Oncology In-patient MDT measures | Specialist Acute Oncology MDT measures |
|---|---|---|---|---|
| Bolton | 67% | 57% | 0% | N/A |
| CMFT | 67% | 80% | 50% | N/A |
| East Cheshire | 60% | 60% | 75% | N/A |
| PAHT | 17% | 56% | 0% | N/A |
| Salford | 67% | 45% | 25% | N/A |
| UHSM | 83% | 100% | 50% | N/A |
| Stockport | 17% | 90% | 25% | N/A |
| Tameside | 33% | 40% | 0% | N/A |
| Wigan, Wrightington and Leigh | 67% | 60% | 0% | N/A |
| Mid - Cheshire | 83% | 78% | 67% | N/A |
| Christie | N/A | 91% | 100% | 100% |

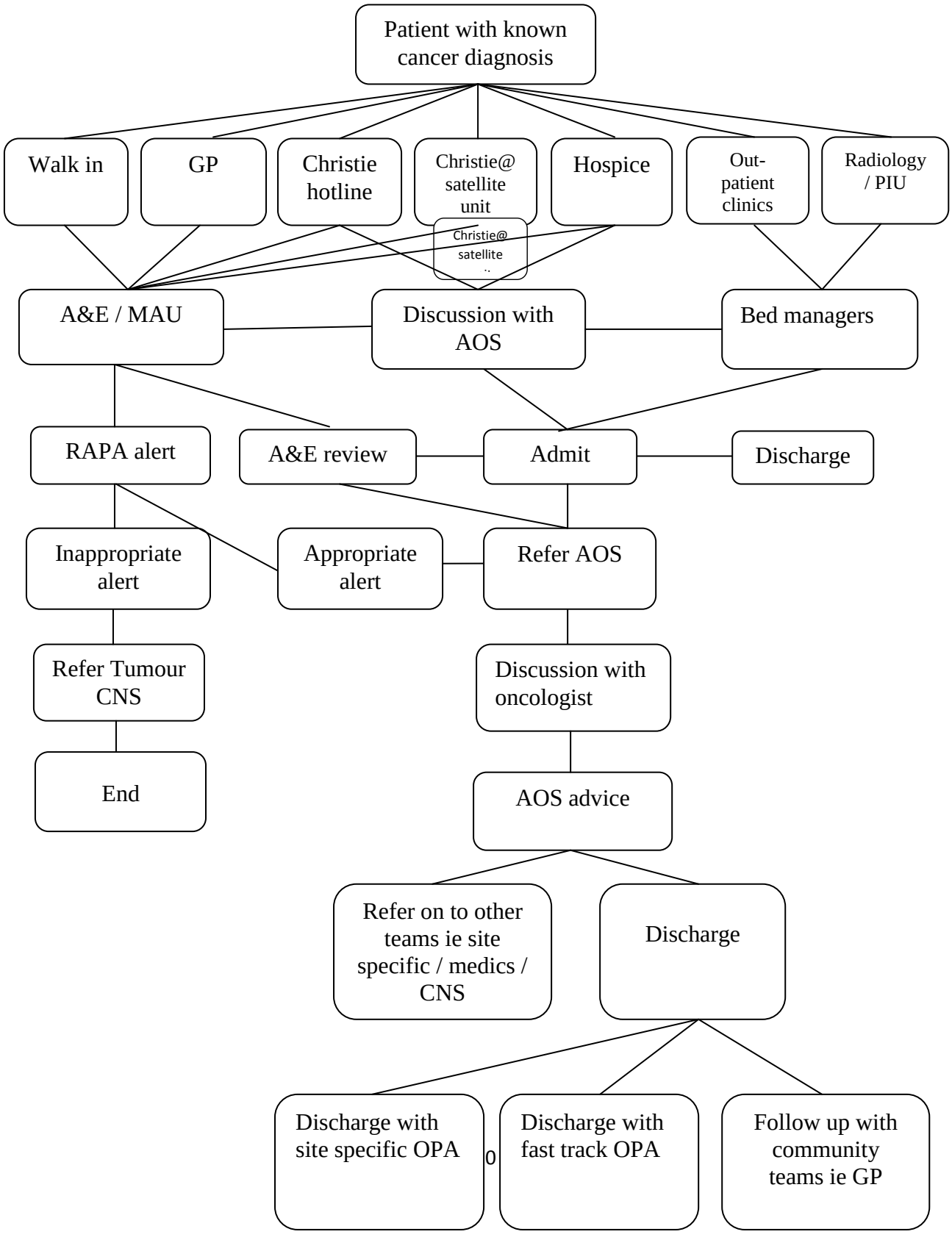
Referral pathways within acute trusts acute oncology services is determined locally and defined within their operational policy however all trusts have established an electronic rapid alert system (RAPA) to identify patients who have a known cancer diagnosis who are admitted acutely to hospital .

The acute oncology management service (AOMS) based at the Christie NHS Trust has a key function in the provision of acute oncology services within Greater Manchester and Cheshire. The Christie hotline provides 24hr advice to patients by trained specialist nurses; the MSCC co-ordinator for the network is based within the AOMS co-ordinating clinical care for patients diagnosed with MSCC within the network and leading on education and training for MSCC;

for health professionals 24 hour advice can be accessed through the oncology on-call service (medical and clinical consultant oncologists on-call plus specialist trainees).

Acute oncology services are at present focused within acute trusts however links have been established with primary care and community services to improve education and training in relation to oncology patient's needs.

The following pathway is an example of the referral routes that acute oncology teams receive patients via on their admission to hospital:



As part of the acute oncology service provision the Cancer of Unknown Primary (CUP) services are also co-ordinated. At present not all trusts have a local CUP MDT established and there are no current plans for the development of a network specialist MDT for CUP due to lack of funding resources.

The CUP services have an independent set of peer review measures that have to be achieved. The current compliance for the trusts within Manchester cancer is shown below:

| Trust | CUP MDT measures | CUP local group measures |
|---|---|---|
| Bolton | 27% | 67% |
| CMFT | 88% | 67% |
| East Cheshire | 81% | 100% |
| PAHT | 63% | 67% |
| Salford | 15% | 0% |
| UHSM | 69% | 100% |
| Stockport | 42% | 0% |
| Tameside | 8% | 0% |
| Wigan, Wrightington and Leigh | 31% | 33% |
| Mid - Cheshire | 38% | 0% |
| Christie | N/A | N/A |

## 4. Clinical guidelines

The Pathway Board/Cross-cutting Board has only been in place since January 2014 and has not yet had the opportunity to review its clinical guidelines and patient pathways. As such, the guidelines created by the previous cancer network group have been adopted until such time as they can be reviewed and updated in the coming year.

All of the relevant documentation has been migrated from the old cancer network website and can now be found at www.gmccn.nhs.uk/home and www.christie.nhs.uk/the-foundation-trust/treatments-and-clinical-services/clinical-services/acute-oncology.

A full list of active current guidelines and their renewal dates will be produced for the next annual report of July 2015.

## 5. Clinical information and outcomes

The previous network group agreed the following minimum dataset and clinical outcome measures to be reported by each of the acute trusts on a monthly basis. The current pathway group has continued to use these measures for data collection at present with a plan to review them in the upcoming 12 months.

1. **Acute Oncology Service activity**:
    - Non-elective admissions at Christie/acute trusts: number of admissions and length of stay
    - Activity data on chemotherapy and radiotherapy treatments delivered at Christie/acute trusts

2. **Data from A & E departments**:
    - Patients identified by alerts
    - Patients triaged to/by Acute Oncology Service
    - Proportion of patients admitted and not admitted (following triage)

3. **Data from acute oncology team (Acute oncology referrals)**:
    - Referrals of patient (categories I – VI); (I - treatment complications, II - cancer emergency, III - new or suspected cancer diagnosis, IV – CUP, V – MSCC, IV – disease progression).
    - Patients seen by acute oncology nurse
    - Patients where contact made with oncology team (Christie oncologist or oncologist based at local trust)
    - Patients where directly reviewed on site by oncologist (within 24 hrs / 1 working day)
    - Patients where directly reviewed on site by specialist palliative care team (within 24 hours/1 working day)
    - Patients where directly reviewed on site by haematologist (within 24 hrs /1 working day)
    - Patients with a CUP

4. **Patients Outcomes**
    - Patient experience
    - Length of stay
    - Investigations (scans and procedures especially in new unknown primary cancers)
    - Deaths within 30 days of active cancer treatment

5. **Door to Needle Pathway**
    - Suspected neutropenic sepsis
    - Confirmed neutropenic sepsis
    - Time to first dose antibiotic (oral or IV)
    - Outcome (death/discharge/admitted and length of stay)

6. **End of Life Outcomes**
    - Rapid discharge pathway
    - Patients on EoLC (End of Life Care) pathway

There are currently no national outcome measures for acute oncology or CUP. Due to limited resources assessment of the data has not been performed in the last 12 months – following review of the outcome measures prospective analysis of the measures will occur this will form part of the work plan for the upcoming 12 months.

As part of peer review compliance the acute teams will prospectively audit their door to needle times for neutropenic sepsis – this will be presented to the pathway board on an annual basis.

Audits for CUP have also been specified by the CUP sub-group and again will be reported back to the board on an annual basis.

## 6. Patient experience

Acute oncology and cancer of unknown primary are not represented in the National Cancer Patient Experience Survey (NCPES) as disease specific sites therefore there are no directly applicable results available from the survey.

The acute oncology pathway board has encouraged the individual trusts to undertake patient experience exercises for their individual acute oncology services.

## 7. Research and clinical trials

As a cross cutting group there are no specific clinical trials relating to acute oncology that are currently being recruited to.

Within the CUP sub-group patients being referred onto the Christie NHS Foundation Trust for consideration of treatment are potentially eligible for the NCRN CUP ONE study (Principle Investigator Dr Claire Mitchell).

The CUP service at the Christie NHS Foundation Trust has abstracts accepted at ESMO 2014 (European Society of Oncology) and has publications in work up for submission.

## 8. Innovation in clinical practice

The MSCC co-ordinator post based at The Christie NHS Foundation Trust was established in September 2013. The stimulus for the development of this post was to improve the care pathways and co-ordination of services for patients presenting with MSCC.

Initially this post was developed as a Network Post however the post is currently being funded by The Christie NHS Foundation Trust.

The MSCC co-ordinator service provides a 24hr service through which clinical teams within the Greater Manchester and Cheshire network can access clinical advice on the management of patients with MSCC. The MSCC co-ordinator liaises with the spinal team at Salford NHS Foundation Trust and the clinical oncology service at Christie NHS Foundation Trust to provide an individualised management for the patients with MSCC which is communicated to the referral team within 4 hours of referral. The service has helped to improve co-ordination of services and clinical teams with efficient clinical guidelines and management pathways to improve patient care and experience.

In addition to their clinical role the MSCC co-ordinator is also active in the provision of education and training both within acute trusts and also the community.

# 9. The Pathway Board

## 9.1. Formation of the Board

The principle of Manchester Cancer Pathway Boards is that they should be professionally and institutionally representative, yet small and manageable in size. To help Pathway Clinical Directors form institutionally representative Boards the Manchester Cancer central team sought nominations from trusts for their representative(s) on 16 of the 20 Pathway Boards. Nominations were not sought for Children's, Sarcoma, Palliative Care and Early Diagnosis as alternative arrangements were necessary in these areas.

For each Pathway Board trusts were asked to provide up to three nominations from a range of professions from which the trust representative(s) could be chosen. The team asked that nominations included a brief statement of the individual's suitability for membership of the relevant Pathway Board.

Nominations were passed to Pathway Clinical Directors who took them into account when forming their Boards. Trusts were informed during this process that Directors would not be obliged to accept all trust nominations but that, if a Pathway Clinical Director wished to appoint a trust representative that had not been nominated by their organisation, and then this would be discussed with the Trust Cancer Clinical Lead.

The pathway nominations were generally accepted by the Pathway Clinical Director with each Trust providing a representative plus a deputy to attend in case of absence. For most Trusts the nominees were either their AO clinical lead or their AONS.

In addition to the representatives from each of the Trusts additional representation was sought from relevant stakeholders' namely emergency medicine, acute medicine, primary care, the strategic cancer network and palliative medicine.

The board's terms of reference and constitution were agreed at the 2nd Acute Oncology Pathway Board meeting held on 25th July 2014.

## 9.2. Membership

The current membership for the Acute Oncology pathway board is shown below:

| ORGANISATION | Pathway Rep (1) | Pathway Rep (2) |
|---|---|---|
| **Royal Bolton Hospitals NHS Foundation Trust** | Clare DeMarcoMasetti (AONS) | TBC |
| **Central Manchester University Hospitals NHS Foundation Trust & Trafford** | Kathryn Hornby (AONS) | Patrick Carrington (Consultant Haematologist) |
| **East Cheshire NHS Trust (Macclesfield General Hospital)** | John Hudson (Consultant Haematologist) | Anne Allen / Catherine Fensom (AONS) / (Lead Cancer Nurse) |
| **Mid Cheshire NHS Foundation Trust (Leighton Hospital)** | Laura Horsley (Consultant Medical Oncologist) | Ann Dingle / Sophie Lloyd (AONS) |
| **Pennine Acute Hospitals NHS Trust** | Keven White (AONS) | Nicola Remmington (Lead Cancer Manager) |
| **Salford Royal NHS Foundation Trust** | Claire Arthur (Consultant Clinical Oncologist) | Ann Davis / Vikki Tyrell (AONS) |
| **Stockport NHS Foundation Trust** | Catherine Coyle (Consultant Clinical Oncologist) | Christine Griffiths (AONS) |
| **Tameside NHS Foundation Trust** | Mel Dadkhah-Taeidy (AONS) | Carol Diver (Lead Cancer Nurse) |
| **University Hospital South Manchester NHS Foundation Trust** | Joanne Humphries (AONS) | Yvonne Summers (Consultant Medical Oncologist) |
| **Wrightington, Wigan and Leigh NHS Foundation Trust** | Elena Takeuki (Consultant Medical Oncologist) | Ursula McMahon/ Barbara Hefferon (AONS) |
| **Christie NHS Trust** | Phil Hajimichael (Consultant Critical Care) | Paula Hall (AONS) |
| **Palliative Care Rep** | Kim Steel (Consultant Palliative Medicine) | N/A |
| **Primary Care Rep (GP)** | Sarah Taylor (General Practioner) | N/A |
| **Acute Physician** | Muhammad Abbas (Consultant Acute Medicine) | N/A |
| **Acute Physician** | Tim Cooksley (Consultant Acute Medicine) | N/A |
| **Emergency Medicine** | TBC | N/A |
| **MSCC Chair / Co-ordinators** | Vivek Misra (Consultant Clinical Oncologist) | Lena Richards / Conor Fitzpatrick (MSCC Co-ordinators) |
| **SCN (Strategic Cancer Network)** | Sue Sykes | N/A |
| **Patient representative** | TBC | N/A |

The group is chaired by the Acute Oncology pathway director Dr Claire Mitchell Consultant Medical Oncology. At present there are vacancies for a representative from Emergency medicine and a patient representative. Approaches have been made in relation to the vacancy in emergency medicine and a representative is likely to be agreed in the near future.

A patient representative will be appointed via the planned Manchester Cancer appointments which are being developed with input from Macmillan. Once a patient representative has

been identified a “buddy” will be allocated to them to ensure that they feel supported when attending pathway meetings.

In addition to the acute oncology pathway board sub-groups have been established to lead on specific areas within the pathway group. These are:

| Sub - group | Chair |
|---|---|
| CUP | Dr Claire Mitchell |
| MSCC | Dr Vivek Misra |
| Education | Conor Fitzpatrick |
| Nurses Forum | Kathryn Hornby |

### 9.3. Meetings

The following meetings of the pathway board and the sub-groups have taken place since January 2014:

| Meeting | Chair | Dates of Meeting | Frequency |
|---|---|---|---|
| AO Pathway Board | Dr Claire Mitchell | 14/03/14<br>25/07/14 | 3 monthly |
| CUP sub-group | Dr Claire Mitchell | 06/05/14 | 6 monthly |
| MSCC sub-group | Dr Vivek Misra | 05/02/14 | 6 monthly |
| Education sub-group | Conor Fitzpatrick | 25/07/14 | 3 monthly |
| Nurses Forum sub-group | Kathryn Hornby | 06/06/14 | 3 monthly |

An attendance record and minutes of each meeting are kept and these can be found in the appendices (2-4).

In addition to the planned pathway and sub-group meeting a scoping exercise in relation to acute oncology education was held. There is also a planned Acute Oncology study day planned at the Christie NHS Foundation Trust on 15th October 2014.

## 10. Progress and challenges to date

Acute oncology services are relatively new services to have been developed in acute trusts. Since 2011 there has been consistent progress in establishing these services within trusts within the Greater Manchester and Cheshire region. Initially these services consisted of AONS with proposal to develop acute oncology non-surgical oncologist posts.

Since Manchester Cancer has been established there has been continuing progress in the development of non-surgical oncologist posts to fulfil peer review requirements for acute oncology. Prior to the launch of Manchester Cancer five of the ten acute trusts had non-surgical oncologist providing support to the acute oncology teams. Since January the remaining five trusts have agreed funding for non-surgical oncologist posts which have either now been appointed or are awaiting appointment. Whilst many trusts remain non-compliant with peer review measures the acute oncology pathway board is working towards the goal of

achieving full peer review compliance agreed a service specification for acute oncology aimed at accomplishing this goal.

One of the most significant challenges for the Acute Oncology pathway group will be resolving the concern of on-going funding for the acute oncology services. At present funding for each individual service varies according to the trust; with some services receiving funding from their CCG whilst others are funded directly from the trust. Agreement needs to be made by trusts to ensure the on-going funding security of the acute oncology services.

A further challenge in relation to funding is the provision of the network wide services namely the “chemotherapy hotline”, MSCC co-ordinator, Clinical portal and provision of 24 hour clinical advice and support that is currently provided by The Christie NHS Foundation Trust through a CQUIN and direct funding from the Trust. Negotiations will be required by the provider board to ensure that funding for these services is safe-guarded to ensuring security of on-going service provision.

The acute oncology pathway group has supported the establishment of an “acute oncology nurses forum” for the Manchester Cancer group to provide support and education to AONS within the region. This is in addition to the previously established sub-groups for MSCC, CUP and Education.

Key to the success of the acute oncology pathway group will be the ability to co-ordinate care across the geographical region and through disease based groups to ensure that all patients receive consistent high quality expert care wherever they may present acutely. This will involve co-ordination with the other clinical pathway boards plus key stakeholders for example primary care, microbiology, emergency medicine/ acute medicine and palliative medicine.

## 11. Vision and objectives

The agreed vision of the acute oncology pathway board is to establish acute oncology services in every acute trust which are fully peer review compliant and have secure recurrent funding agreed with a view to extending these services provided by acute oncology teams namely out-patient and community support. An integral part of the acute oncology service provision are the “network” services based at the Christie which require a secure funding source to be established through agreement of the representatives on the provider board. The acute oncology pathway board hope to facilitate this agreement safeguarding the future provision of these services

The following are the objectives for the board for 2014/15:

- To aim for Manchester Cancer acute oncology services to be fully compliant with the agreed Manchester Cancer Service Specification and National Cancer Peer Review Programme measures.
- To ensure that acute oncology services within Manchester Cancer (both local and network based) have recurrent funding established to safeguard acute oncology service provision.
- To expand the membership of the acute oncology pathway board to ensure representation of all relevant stakeholders.
- To continue the on-going work in the established sub-groups to focus development on CUP, MSCC, education and the nursing forum.

- For the board to collaborate with the Christie NHS Trust to look to expand the role of the acute oncology services in conjunction with the expansion chemotherapy delivery services.

The overall aim of the Acute Oncology pathway board is to ensure that all patients in Greater Manchester and Cheshire have equitable access to safe, patient centred, high quality and efficient acute oncology services.

# 12. Appendix 1 – Pathway Board Terms of Reference

## Acute Oncology Cancer Pathway Board

### Terms of Reference

These terms of reference were agreed on 25th July 2014 by Dr Claire Mitchell, Pathway Clinical Director for Acute Oncology 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.

### The Pathway Board

The Acute Oncology 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 the hospital trusts that are involved in the delivery of Skin cancer care in Greater Manchester. The Pathway Board also has membership and active participation from primary care and patients representatives.

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

### 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.

## Purpose of the Pathway Board

The purpose of the Pathway Board is to improve cancer care for patients on the Greater Manchester Acute Oncology 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 lung 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.

## Role of the Pathway Board

The role of the Acute Oncology Cancer Pathway Board is to:

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

## 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 lung 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
Oncology
Specialist nursing
Operational management
Primary Care rep
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.
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.
Each member will have a named deputy who will attend on the rare occasions that the member of the Board cannot.

## Frequency of meetings

The Acute Oncology Cancer Pathway Board will meet every Three months.

## Quorum

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

## 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.

# 13. Appendix 2 – Pathway Board meeting attendance

**Acute Oncology Pathway Meeting**
**14/03/2014**

| NAME | POSITION | ATTENDED |
|---|---|---|
| CLAIRE MITCHELL | CONSULTANT MEDICAL ONCOLOGIST | ✓ |
| CAROLINE McCALL | PATHWAY MANAGER | ✓ |
| CHRISTINE GRIFFITHS | ACUTE ONCOLOGY ANP | ✓ |
| SUE SYKES | QUALITY IMPROVEMENT MGR | ✓ |
| SARAH TAYLOR | MACMILLON GP SOUTH MCR | ✓ |
| BARBARA HEFFERNON | ACUTE ONCOLOGY NURSE | ✓ |
| CLAIRE ARTHUR | CONSULTANT CLINICAL ONCOLOGIST | ✓ |
| JO HUMPHREYS | AO NURSE | ✓ |
| CLARE DE MARCO MASETTI | AO ANP | ✓ |
| CATHERINE FENSOM | MATRON IN ONCOLOGY | ✓ |
| VIKKI TYRRELL | AONP | ✓ |
| M ABBAS | CONSULTANT ACCUTE MEDICINE - SRFT | ✓ |
| ANN DAVIS | AONP – SFRT | ✓ |
| CONOR FITZPATRICK | MSCC CO-ORDINATOR/THERAPY RADIOGRAPHER | ✓ |
| VIVEK MISRA | CONSULTANT CLINICAL ONC, KSCC LEAD | ✓ |
| KATHRYN HORNBY | TEAM LEADER ANP ACUTE ONCOLOGY | ✓ |
| SOPHIE CLOYD | AO CNS | ✓ |
| LEO FAIHARIADES | ONS ACUTUE MEDICINE – BOLTON | ✓ |
| MELANIE DALKHAH-TAEDY | AO CNS | ✓ |
| CAROL DIVER | LEAD CANCER NURSE TGH | ✓ |

# 14. Appendix 3 – Pathway Board minutes to 31st July 2014

## ACUTE ONCOLOGY PATHWAY BOARD MEETING MINUTES

## DATE: 14th March 2014

**In Attendance:**

**Claire Mitchell – Pathway Director**
**Caroline McCall – Pathway Manager**
**Christine Griffiths**
**Sue Skyes – Quality Improvement manager (SCN)**
**Sarah Taylor – Primary Care representative**
**Barbara Heffernon**
**Claire Arthur**
**Jo Humphreys**
**Clare De Marco Masetti**
**Catherine Fensom**
**Vikki Tyrrell**
**M Abbas**
**Ann Davis**
**Conor Fitzpatrick**
**Vivek Misra**
**Kathryn Hornby**
**Sophie Cloyd**
**Leo Faihariades**
**Melanie Dalkhah-Taedy**
**Carol Diver**

### Aims & Priorities of Pathway group

**Improving outcomes, survival rates and improving processes whilst remaining focussed on patient experience, Research and education. Moving from where we are now to a more patient focussed approach.**

1. Introduction to Manchester Cancer, its aims, objectives and its new role looking at the whole integrated pathway including representative from primary care, and patients. It was experience that Manchester cancer outcomes focusing on:
    i. Patient experience
    ii. Clinical engagement
    iii. Research
    iv. Education

    To achieve its aims and objectives and to improve skin cancer outcomes.

    There was further discussion around the idea of having one rep per trust and to have a named deputy who can attend should the member be unable to attend. It was

agreed for the group to be no bigger than 20 members to ensure efficiency and focus.

**Action: CM/CMC finalise board membership**

2. Discussion around peer review compliance. Pennine is the only trust in the Greater Manchester to be peer reviewed this year. There were concerns this may not be met due to geographical limitations due to 4 different sites and having adequate cover for AO service. Various on-going discussions are going on with commissioning and MC regarding funding arrangements for AO service. These have not all been finalised just yet across Greater Manchester.

**Action: CM/CMC working together on negotiations regarding funding and peer review compliance.**

3. Clinical Guidelines including Neutropenic sepsis – it was agreed that we need to contact micro – Ken Dutton.

**Action: CM to contact Ken Dutton for further advice.**

4. Sub-Group development including education and training, nurses forum, pathway development and data analysis/performance. During the meeting we had volunteers for education and training – Connor Fitzpatrick. Kathryn Hornby volunteered to lead the Nurse forum and to look at patient surveys. It was agreed we would not have someone for the pathway development role as it was felt the board would fulfil this role and finally, Data analysis would be sent to Caroline McCall

**Action: Connor to provide the next education event**

**Date of next meeting is: 25th July 2014**

# Network Cancer of Unknown Primary Site Specific Group

**Tuesday 6th May 2014**
**Library Seminar Room, Christie Hospital**

**Chair: Dr Claire Mitchell**

**Attendees:**

| Name | Initials | Name | Initials |
|---|---|---|---|
| Anne Allen | AA | Claire Mitchell | CM |
| Jo Humphreys | JH | Catherine Fensom | CF |
| Sarah Latham | SL | | |
| Catherine Coyle | CC | | |
| Jonathan Elliott | JE | | |
| Paul O'Donnell | PT | | |

**1. Apologies**

| Name | Initials | Name | Initials |
|---|---|---|---|
| Ursula MacMahon | UM | | |
| Yvonne Summers | YS | | |
| Elena Takeuchi | ET | | |
| Keven White | KW | | |
| Vicki Tyrell | VT | | |
| Christine Griffiths | CG | | |
| Clare DeMarco-Masetti | CDM | | |
| | | | |

| No. | | Action |
|---|---|---|
| 1. | **Introduction:**<br>• All members introduced | CM |
| 2. | **Terms of reference and constitution:**<br>• CM discussed terms of reference and constitution which all agreed | CM |
| 3. | **Membership of CUP Sub Group**<br>• CM discussed the need for a wider membership group which may include, 2 user representatives (these can be patients, carers or other non oncology Physicians. The group also needs a Radiologist (Ben Taylor was suggested). The group would also benefit from a Histopathologist and a Palliative Care Lead. CM asked the group to consider nominating appropriate candidates and email her directly with suggestions.<br>• JH suggested that some of the Medical Consultant at UHSM may be interested especially those who may cover the Christie MAU (Tim Crooksley was suggested). | CM |
| 4. | **Clinical Pathways**<br><br>**MUO Investigation Pathway:**<br>• CM asked the groups opinion on the pathways and their format. | CM |

| | | |
|---|---|---|
| | The group were happy with this and had no initial recommendations.<br>• CC highlighted that the AOS CNS at SHH has devised an MUO poster to aid compliance and increase awareness of the pathway. CC will forward this onto CM to cascade.<br>• CM/ JE discussed the benefits of the MUO pathway<br><br>**Treatable Syndromes Pathway:**<br>• Referral for treatable syndromes pathway discussed no changes where suggested re this.<br>• Neuroendocrine pathway was discussed by CM no changes were suggested<br>• Peritoneal nodes, midline disease and solitary metastases pathways where discussed and no changes were suggested | |
| 5. | **Managerial Pathways**<br>• CM feels that the site specific/ pathway leads need to be involved in this, CM will liaise accordingly.<br>• Non specific cases are usually referred to CUP MDT assessed then referred on<br>• JH discussed that there are some CUP patients that she is not made aware of till they are discussed at the CUP MDT, the group agreed with this and feel that it can be a problem<br>• CM highlighted that promotion of the CUP service is key to improve referrals<br>• JH also highlighted that at time sit is difficulty when MUO patients are having investigations as per the pathway it can be difficult to follow them up. | CM |
| 6. | **Referral Pathways**<br>• The group discussed that it would be beneficial to have a more formalised spinal bone biopsy pathway. CM will liaise with spinal team at Hope<br>• CM enquired if the group felt that their patients are referred to appropriately to the local CUP MDT's. Group agreed on the whole they are.<br>• CM asked patients are being reviewed within 24 hours of referral most of the group agreed | CM |
| 7. | **Patient experience**<br>• CM discussed obtaining patient experience data through a variety of mediums such as questionnaires, patient interviews etc<br>• JE highlighted that each patients case should be reviewed first as some patients will be too unwell or distressed | CM |
| 8. | **Outcomes and Audit**<br>• At present no clinical outcomes specified within peer review measures for 2014<br>• Peer review suggests 10 types of data collection for audit. The group agreed that the data to be collected is:<br>**1.** Number of patients (audit 1 of peer review list)<br>**2.** Time between a patients being referred to the local CUP service to the assessment of the patient by the local CUP team. (audit 7 of peer review list) | CM |
| 9. | **Next meeting**<br>• Meetings agreed 6 monthly. CM will be in touch re next date<br><br>**NEXT MEETING TUESDAY 04/11/14 10:00 – 12:00**<br>**SEMINAR ROOM 6, EDUCATION CENTRE, CHRISTIE** | CM |

**Metastatic Spinal Cord Compression (MSCC) Group Meeting**
**Wednesday 5 February 2014, 2pm – 4pm**
**Room 6, Trust Headquarters, The Christie Hospital**

**Notes and Actions**

| Role | Name | Organisation | Attended |
|---|---|---|---|
| Chair | Dr V Misra | The Christie NHS FT | Y |
| Surgeon | Mr R Verma | Salford Royal FT | N |
| | Mr V Tandon | Stepping Hill Hospital FT | Y |
| AOS Consultant | Dr C Coyle | The Christie NHS FT | Y |
| Radiologist | Dr C Soh | Salford Royal FT | N |
| AOS Nurse | Kathryn Hornby | Central Manchester NHS FT | Y |
| | Christine Griffiths | Tameside Hospital NHS FT | N |
| | Vickki Tyrrell/Ann Davies | Salford Royal FT | Apologies |
| | Ursula McMahon/Lorraine Bremner | Wigan Leigh and Wrightington FT | Y |
| Palliative Care | Pauline Wharburton | Bolton NHS FT | Y |
| | Dr Katie Hobson | Salford Royal FT | Apologies |
| AHP | Tina Coe/Lucie Casserley | The Christie NHS FT | y |
| | Ursula Howarth | Central Manchester NHS FT | N |
| | Caroline Lloyd | Salford Royal FT | Apologies |
| Primary Care | Dr Matthias Hohmann | Oldham CCG | N |
| | Dr Sarah Taylor | South Manchester CCG | Y |
| MSCC Coordinator | Lena Richards | | Y |
| User Representative | David Makin | | Y |
| Christie MSCC Educator | Conor Fitzpatrick | The Christie NHS FT | Y |
| Network Logistical Support | Sue Sykes/Denise Woolrich | SCN | N |

## 1. Apologies

Apologies noted, as above.

## 2. Minutes from 06/11/13 and matters arising

The minutes were accepted as a true record of the minutes from 6/11/13

Matters arising: all complete or on agenda.

**3. Membership**

Pauline Wharburton was welcomed to the group as the Palliative Care Nurse representative.

Lucie Casserley will deputise for Tina Coe whilst Tina is on maternity leave. Lorraine Bremner stood in for Ursula McMahon.

It was agreed to invite Dr Claire Arthur, Clinical Oncologist and AO consultant at Salford Royal to the group.

**Action:**

**VM to invite Dr Arthur to join the group**

.

**4. MSCC co-ordinator service**

LR and CF updated the group about the progress since the launch of the service in November 2013. Between 35-39 patients a month are being referred via the service, though there are more calls being handled for giving advice to clinicians unsure about how to investigate /manage patients. About half of all referrals are confirmed MSCC.

Over all it is felt that the service is running well. There have been a few teething issues, but each of these has been dealt with promptly by the team. LR also attended a pathway meeting at Salford Royal and this was successful in providing the impetus for streamlining the SRT surgical pathway.

It has become clear that there is a need to work on a pathway for managing impending MSCC. A large number of calls pertain to this and currently there is no pathway/guidance to manage this.

Spinal Stability is another issue causing confusion. Referrers are not clear about who's responsibility it is to assess this. Some local teams feel they are unable to assess stability. LR advised that no more than 10% of patients have an unstable spine; hence there is a need to assess stability early on to prevent the other 90% from being put on strict bed rest.
The SINS score (paper enclosed) was discussed. LR has liaised with the London group and they are looking at this score. However, it is not a validated score and has several limitations.

It was agreed that we will work on a simplified, flow-chart type model to help local teams to decide on spinal stability. Continuing education is important and the Christie based team will continue to support local teams in this regard.

There is also some clarification required about the need for spinal support (collars/braces). It is not clear who's responsibility it is to fit there and also when to remove them. This will be included in the updated spinal stability guidance.

LR highlighted the issue of admissions to A&E where the A&E team either di not know what to do or felt that the patients needed to be assessed by the spinal team or orthopaedic team doctor. There is also a reluctance to admit 'palliative' patients from the hospices. This needs to be dealt with by each hospital to ensure that they have a robust internal pathway. VM will raise this at the AOS pathway meeting.

Whilst the pathway is working well, we need formal feedback from users (AO teams/CO trainees) and ideas for improvement

**Actions:**

**LR/VM/CF to work on new spinal stability assessment guidance**

**VM to discuss issue of A&E admissions at the AO Pathway meeting**

**VM/LR/CF to design feedback questionnaire**

**VM to send SINS paper to the group**

## 5. Education and Red Flag Cards

LR/CF are continuing to support local trusts and community education events. Education within trusts to remain responsibility of local Acute Oncology teams, assisted by LR/CF/VM

ST will get MSCC added to the education agenda of a meeting for all Macmillan funded GPs on 30/4/14. CF will present at the meeting.

It was agreed to contact the practice managers and send out the Red Flag cards electronically to them for distribution to their GPs

**Actions:**

**VM: to contact practice managers to disseminate Red Flag Cards**

**LR/CF to continue with education programme,**

## 6. Guidelines

Long discussion about the surgical pathway. VM explained the reasons for keeping on SRFT as the sole surgical site for MSCC. Number of patients operated each year, outcome audit, need for 24/7 specialist spinal cover and 24/7 MR availability for diagnosis and investigating post surgical complications were all relevant points.

VT explained that at SHH there is a good AO service with a new AO nurse in place and that a current audit is collecting data on numbers/outcome of patients treated in the past. VT clarified that at SHH only compressions below T4 level could be operated on.

VT felt that having just one unit could cause issues with bed availability and delays with treatment and that moving patients from SHH to SRFT for surgery may not be in the patients best interest if the procedure could have been performed locally.

Overall, it was felt that for now the pathway would remain with SRFT as the sole surgical site, but VM will explore the possibility of more collaborative working between SRFT and SHH as a way forward. VM will also raise this at the Provider Board level via Claire Mitchell.

The second surgical issue was the insistence of SRFT (recently) requiring biopsy before operating on MSCC due to CUP. This is not in the current pathway and causes delays in treatment. The group felt that this step was not necessary. VM will contact SRFT regarding this.

**Action:**

**VM to discuss a more collaborative working with SRFT and SHH and raise this issue with Claire Mitchell.**

**VM to liaise with SRFT spinal team regarding biopsy before surgery for CUP patients**

## 7. Pathway

The current pathway is largely working well. The need for a pathway for impending MSCC was discussed (see section 4 above)

**Action:**

**As per section 4**

## 8. Audit

The internal audit at The Christie led by CF has started and we should have results soon.

LR is undertaking the bench maring audit and also liaising with the informatics team at The Christie to start generating reports later this year for the group.

Functional outcomes will also be collected from later in the year, where possible.

**Action:**

**LR/CF to update group at the next meeting**

## 9. Any other business

Following a recent incident at Bolton it was identified that the communication fro The Christie to referring hospitals after RT needed to be strengthened. CF distributed an immediate discharge letter to the group. This will be finalised and used by the RT team at The Christie shortly. Comments were invited from the group but in the whole the group felt that this was a good initiative.

**Action:**

**CF to collate responses and finalise the immediate discharge document**

## 10. Date and time of next meeting

**2-4 pm, 28 May 2014 Wednesday , Meeting Room 6, Trust HQ, The Christie**

# Manchester Cancer Acute Oncology Nurse Forum

**Notes from first meeting**
**Wednesday 6th June 12.30-17.00**
**CMFT**
**Sponsored by GSK**

## Attendees

Kathryn Hornby, Central Manchester
Johnathan Elliott, Central Manchester
Sarah Wilks, Central Manchester
Phillippa Jones, Macmillan/UKONS
Sarah Latham, Mid Cheshire
Melanie Dadkah-Taeidy, Tameside
Lorraine Bremner, Wigan
Vikki Tyrell, Salford
Christine Griffiths, Stockport
Vanya Walmsley, Bolton
Clare de Marco Masetti, Bolton
Rena Flecther, Central Manchester

## Apologies

Paula Hall, Christie
Liz Eccleston, Pennine
Tracy Wild, Pennine
Jo Humphreys, South Manchester

## Presentations

1. Pazopanib, Salim Jogee, GSK
2. Medical Aspects of Cancer of Unknown Primary, Dr Claire Mitchell
3. Setting up an Acute Oncology Forum and national agenda for Acute Oncology, Philippa Jones
4. Advanced Neutropenic Sepsis/MASCC score, Dr Doug Brand

## Forum Discussion Points

- Aim to meet bi-monthly – preferably tues, weds or thurs
- Possible funding from industry to sponsor meetings
- Next meeting likely to be at Birchwood, Warrington in August 2014
- Meetings should have a) educational aspect b) case based discussion c) forum discussion
- Arrange speakers for forums e.g. oncologists, spinal surgeon, neuroendocrine CNS.
- Common themes and issues to be raised at Manchester Cancer Acute Oncology Pathway Meetings
- Take it in turns to discuss unusual cases.
- Keep a loose agenda, however no need for formal minutes at forum.
- Terms of reference not required
- KH happy to do agendas/organise meetings
- Minimum attendance of 6 nurses, otherwise cancel session.
- Forum to be kept for acute oncology nurses only.
- Discussion regarding funding possibly Macmillan??

- Time to discuss and share problems faced/issues in service.

**Group Work, improving patient pathways**

- Neutropenic sepsis
- MSCC
- CUP

**Actions**

- Christine to email group her MASCC form and happy to discuss at next forum
- Salford to email group their MSCC ?nurse checklist
- Ask CM whether interested in doing patient experience research on neutropenic sepsis with Douglas Brand
- KH to email group with radiotherapy transfer guidelines/check list

**Plans for next meeting**

- Discuss MASCC scoring further
- Discuss Macmillan funding further
- Case based discussion
- Aim to organise speaker

**Aim to meet in August 2014**

KH will circulate further details

**Minutes of the Acute Oncology Education Sub-group**

Fri 25/7/14 @ 13.30

**Present:** Claire Mitchell, Paula Hall, Conor Fitzpatrick, Catherine Coyle, Vanya Walmsley, Barbara Hefferon, Christine Griffiths, Melanie Dadkhah, Anne Allen, Sarah Wilks, Joanne Humphreys.

**Apologies:** Kathryn Hornby, Tracy Wild, Ursela Mc Mahon, Clare De Marco, Ann Davis, Vicki Tyrell.

## 1.0 Sub-group Aims

Conor opened the first meeting by discussing the aims and specific focus of this sub-group, these are:

- To highlight and share good practice throughout the local acute oncology services
- Create a 'pathway alliance' with our district general hospitals to ensure that education and training throughout the network of hospitals is both adequate to the needs of each hospital, and consistent so that patients receive the same high quality of care in each hospital
- To identify Acute Oncology training needs, and provide support to meet these

## 2.0 Methods of meeting the needs of each group

The group recognises that there are various professional groups that require acute oncology training. It is important that we provide levels of training to meet each needs.

| **Level** | **Resource** | **Staff Groups** |
|---|---|---|
| Beginner | Acute oncology e-lite bite - Discussion has taken place about using and adapting the Macmillan learn-zone online tool. | All staff |
| Intermediate (staff with an interest / active involvement with oncology patients) | Study day – Education on the background and diagnosis of the key acute oncology emergencies, risk factors, guidance and contact information. | Nurses / AHPs and Junior doctors |
| Advanced | Study days (course / weekend) – Providing advanced information beyond recognising the symptoms of an AO emergency. Direct teaching from clinicians on the management / medications and potential further problems. | A+E teams (doctors / nurses), Acute oncology and ANP's |
| Formal qualification | Masters accreditation – Level 7 Discussion to take place with the Christie School of Oncology and | Nurses / AHPs |

| | | |
|---|---|---|
| | local universities. | |

**3.0 Acute Oncology Education Event – <u>15 October 2014</u>**

An Acute Oncology scenario based study day has been organised for October 15th 2014. A flyer has been included with the minutes. Can all members please circulate this around their clinical area. It is aimed at junior doctors, A+E staff, nurses and AHP's.

**4.0 Access to training / education**

All members of the sub-group identified difficulty in getting staff to complete training; with the largest issue being the difficulty getting time for them to attend training due to various work pressures.
It is also widely understood by the group that many staff which are interested in Acute Oncology, have already accessed information and training; it is important that we therefore target those staff that do not actively participate in training by bringing training closer to them on their clinical sites (possibly carry out training over lunches etc).
There is difficulty in getting the level of training required in order to become more specialist in clinical roles – Staff agree that a module would be useful and good to access by staff. This is currently in discussion with the Christie School of Oncology.

**5.0 Acute oncology education needs**

In order to understand current shortfalls in Acute Oncology education, the sub-group have been asked to supply Conor with areas where they feel there is a specific need to focus education.
**Action – Conor will send out a short questionnaire and collate results prior to next meeting. The questionnaire will ask individuals to highlight any acute oncology emergencies that are not being well handled, as well as areas such as specific wards or staffing groups that members feel need to be focused on.

**6.0 Date / Time of next meeting**

The group has agreed the future meetings will be held in the hour prior to the start time of the pathway group. This will hopefully help to ensure that as many members of the group are able to attend.

# 15. Appendix 4 – Pathway Board Annual Plan 2014/15

## Acute Oncology Pathway Board Annual Plan 2014/15

| Work-Plan 1<br>Framework for an Integrated Pathway | | | | | | |
|---|---|---|---|---|---|---|
| **Action Number** | **Key Areas** | **Aim** | **Milestones / Action Plan Details** | **Director / Clinician Responsible** | **Target Date** | **Progress** |
| **1.** | **Defining MC Acute Oncology Pathway Quality Standards:** | | | | | |
| 1 | **Expansion of pathway board members to represent service users** | To ensure representation of all stakeholders with direct links with acute oncology services | All pathway members engaged in process to ensure representation from all provider trusts with expertise throughout pathway | Claire Mitchell | September 2014 | **Representatives from acute medicine, primary care and palliative medicine have been appointed. Require representation for emergency medicine – pathway board members have provided possible candidates.** |
| 2 | **Define MC Acute Oncology Pathway Outcome Measures** | Define a list of clinical outcome measures to monitor performance against the agreed quality standards. | Cover entire pathway Feasible, reproducible and an accurate reflection of performance against quality standards | Claire Mitchell | October 2014 | **Clinical outcome measures previously defined by the SCN. These need refining and approving by the pathway board.** |
| 3 | **Acute Oncology KPIs** | Define list of MC Acute Oncology KPIs | To ensure high quality service throughout Greater Manchester and Cheshire<br>KPIs to be discussed with local cancer commissioners | Claire Mitchell | October 2014 | **KPIs previously defined by the SCN. These need refining and approving by the pathway board prior to being discussed with the commissioning board.** |
| **2.** | **Expanding the role of Acute Oncology Services:** | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 4 | **Mapping of patient referral pathways** | To determine baseline arrangements, capacity, attendance, access to services etc | Report on current arrangements to inform proposals/models for Acute Oncology service arrangements going forward | Claire Mitchell Caroline McCall | October 2014 | **Initial data from The Christie AOMS team is being reviewed to determine current referral pathways and outcomes.** |
| **3.** | **Governance and Quality Control:** | | | | | |
| 5 | **Define a minimum dataset for collection Acute Oncology Services in Manchester Cancer** | A minimum dataset incorporating clinical and performance indicators | To allow assessment of local services and comparison of achievements within Manchester Cancer | Claire Mitchell | October 2014 | |
| 6 | **Completion of pathway specified clinical audits** | Clinical audits to be undertaken by local AOS – including neutropenic sepsis, MSCC and CUP. | To allow assessment of local services and comparison of achievements within Manchester Cancer promoting sharing of good clinical practice | Pathway Board Members | March 2015 | |

| **Work-Plan 2<br>Core Objectives** | | | | | | |
|---|---|---|---|---|---|---|
| **Action Number** | Key Areas | Aim | Milestones / Action Plan Details | Director / Clinician Responsible | Target Date | **Progress** |
| **Patient and User Involvement and Feedback** | | | | | | |
| 7 | **Patient representative member(s) of pathway board** | At least 2 cancer patient representatives to become members of the Acute Oncology Pathway Board | Recruitment in line with MC Patient Involvement Charter and Action Plan<br>Patient representative "buddy" to be nominated to provide support both inside and outside meetings | Claire Mitchell<br><br>Caroline McCall (and MC Core Team) | Dependant on MC recruiting to MC Patient Reference Group | |
| 8 | **MC Acute Oncology Pathway Patient Experience** | To develop a universal MC Acute Oncology Patient Experience Survey questionnaire for use within acute | To develop a draft questionnaire to be agreed by the pathway board | Claire Mitchell | March 2015 | **Initial draft questions being developed** |

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| | **Survey questionnaire** | trusts | | | | **to be taken to the next pathway meeting.** |
| **Research** | | | | | | |
| **9** | **MC Acute Oncology Pathway Clinical Trial Portfolio** | To aim to develop a MC Acute Oncology Pathway Clinical Trials Portfolio for acute oncology and CUP | Recommend trials suitable for primary care/community, secondary care and tertiary care | Claire Mitchell | March 2015 | |
| **Education** | | | | | | |
| **10** | **Acute Oncology education event** | To host regular acute oncology education events in collaboration with the Christie NHS Trust and Christie School of Oncology | An on-going programme of acute oncology education is already established, the board will help support the delivery of this. | Conor Fitzpatrick Paula Hall | Nov 2014 | |
| **11** | **Host regional GP/Primary Care Education Events** | Acute Oncology Pathway Board to engage in MC Regional GP education/engagement events | The establishment of the Acute Oncology Education sub-group to focus on delivery and expansion of acute oncology education programme | Conor Fitzpatrick Claire Mitchell | Sept 2014 | |