GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Lung Pathway Board

Meeting room 6, Christie Trust HQ

Minutes of the meeting held on 16th January 2017 at 2-5pm

Attendance	Representation
Neil Bayman	Pathway Director
Claire O'Rourke	Pathway Manager
Carol Diver	Nurse consultant, Tameside
Coral Higgins	Commissioning Manager, GM CCG
Paula hall	Lung CNS, Pennine- **apologies**
Durgesh Rana	Consultant Cytopathologist, CMFT-
Ben Taylor	Radiology Consultant, Christie
Richard Booton	Respiratory Consultant, UHSM
Duncan Fullerton	Respiratory Consultant MCHT- **apologies**
Simon Bailey	Respiratory Consultant CMFT
Jane Weir	Lead Lung Cancer Nurse Pennine- **apologies**
Leena Joseph	Consultant Histopathologist UHSM
Anne-Marie Quinn	Consultant Histopathologist UHSM
Christine Eckersley	Lung CNS,Bolton
Vee Sibanda	Lung CNS, Wigan
Carolyn Allen	Radiology Consultant, Pennine
Jane Ashworth	Manchester Cancer project manager
Helen Sparkes	Lung CNS MRI
Fiona Blackhall	Medical Oncology, Christie
Phil Barber	Respiratory Consultant, UHSM
John Shuttleworth	Person affected by cancer

	representative
David Woolf	Clinical oncologist, Christie
Nick Clew	Person affected by cancer representative
Alicia Conway	Lung Registrar Christie
Jayne Holme	Respiratory Consultant,UHSM
Maireed Dixon	CNS,UHSM
David Weir	Respiratory consultant Pennine
Carol Farran	CNS Stockport
Suman Das	Respiratory consultant, Stockport
K. Rammohan	Thoracic surgeon UHSM
Ram Sundar	Respiratory Consultant WWL
Phil Crosbie	Respiratory consultant, UHSM
Matt Evison	Respiratory consultant, UHSM
Lisa Gallagher Dawson	Cancer Manager Bolton.

1. Welcome and introductions/ minutes.

NB welcomed all everyone to the meeting and noted the apologies received. Minutes of the last meeting approved, some names were missed off attendance list COR to correct. Sub-group work plans discussed. All board members went into respective sub-group discussion as agreed for the first hour of the board meeting.

Formal board discussions:

2. Cancer Data pack update: Neil Bayman

Discussion summary	Lisa and NB discussed the new data pack that Lisa and the cancer managers have developed. Excellent piece of work and will be a great tool to get robust data on differences in pathways across GM. This has been done in 3 pathways, with first piece of work on time to first appointment. Wide variation across the board in GM was noted, aim is to gather date on key issues related to standards including Time to CT reporting, EBUS/PET time to diagnosis. Reviewing of 'send out for treatment', when patients are being treated. This work will aim to look at gaps and get the balance. LGD discussed that the data is extracted from CRIS and summerset and will be reviewed at each of the 3 pathway boards in the next few months. NB asked how it is feedback to the clinicians. This data is sent monthly to the Directors Of Operations. Request therefore that Trusts circulate to lung cancer leads via cancer managers. A full review of this data will allow for adaptation to meet the needs of the Lung cancer standards. Look at Trusts which have made improvements and variation across the Lung Cancer centres.

Conclusion	**Excellent piece of work and much needed data particularly for the faster and better diagnosis work group and other areas.**
Actions & responsibility	**To be reviewed at the next pathway board,** **Any comments back to LG-D.** **COR to send out to board members-completed.**

3. Research and innovation: Chair Fiona Blackhall.

Discussion summary	FB presented slide set on updates on research sub-group. FB discussed names have been allocated to the group, this was agreed. Surgeon required for this. FB discussed the 6 key objectives of the Manchester cancer plan, the most relevant to this being reducing smoking rates and 1 year survival and avoidable cancer deaths. FB next discussed the work of the 100k Genome project, information leaflets discussed and distributed all board members keen to support. GM opened later than other centres, Manchester is behind but a concerted effort is being carried out to increase numbers. This has been discussed at cancer board. NHS England to put in structures for molecular diagnostics to facilities this kind of tumour analysis. PED was discussed, Professor S. Moncada leading and early prevention work is essential. Annual education day discussed on the 17th March and FB discussed the meeting with healthier futures on the GM plan to reduce smoking. Meeting invite will be sent out to the board member via COR. FB introduced Phil C, who presented on the prevention and early detect work and screening programme in lung at UHSM. Funding from NCRC to take blood and sputum samples on the second round of the screening has been agreed, this will fund a support truck to do this work with CNS support to get patient experience, psychological assessment and questionnaires. PC discussed his successful in grant application to Yorkshire cancer research, funding of £5.2m for a screening trial in Leeds. Opportunity to get more data on screening and bio-marker research. Review screening service heart exploration and heart disease.
Conclusion	**Need to increase 100k Genome programme of work and update in Manchester all board members have a responsibility for this.** **Study day on the 17th March 2017, all board members to save the date.** **Update on UHSM screening project will be produced for the next board meeting in April when data should be available.**
Actions & responsibility	**Further discussion on this subgroup will take place prior to the next board meeting COR and FB.**

4. Mesothelioma Update: Mairead Dixon.

Discussion summary	Mairead is the new specialist nurse in the team replacing Lorraine, based at UHSM. It was discussed that the message about the regional MDT has got out there and everyone is aware. MD highlighted the national lung cancer audit is out with mesothelioma update. PB highlighted we must be seeing quite high numbers now; service appears to be working well. SD raised the issue that should all palliative patients be sent to regional MDT, breaching of patients due to waiting for the sector MDT. It is essential for the service to run efficiently that there should be one point of contact for

	patients to be discussed.MD discussed the issue of the quality of information received and standardising information sent to the team. Some discrepancies between the sector MDT and meso MDT, outcome is emailed back to referring hospital, waiting for P16 sometimes there are delays. NB discussed the importance of ensuring that we do not have patients breaching due to sector MDT's. LG-D discussed that she wasn't aware that the regional MDT existed, she will feed this back to other cancer managers.
Conclusion	**Regional mesothelioma MDT is working well, need to ensure all areas are aware including cancer managers.**
Actions & responsibility	**Need to feedback next time on process and COR to send to LG-D Mesothelioma team contact details. Request to bring information back next time.**

5. GP update 2WW: Neil Bayman

Discussion summary	**Two week wait update:** document was circulated to board members for comments. NB discussed the Referral form distributed by Sarah Taylor: shown as the Vague cancer symptoms form. Opinion from the board if it could be approved today. NB discussed that section that has 'reason I am concerned about cancer is'…is often left blank by the GP. PBarber discussed his concern about the tone of the form, concerned but not mentions its cancer? RBooton suggested do we need as many boxes? And discussed that all boxed on the form should be mandated so if they are not completed they are rejected?-require the electronic system. CHiggins suggested that the mandated sections have information on them currently which is an option of' not know' which is causing a lot of the errors. Trial in Manchester will change this. All GPs will be chased up by if the referral is not completed. Board discussed it should not be called a 2WW if we are aspiring for the patients to be seen in 7 days, we should be calling this suspected cancer referral. LGDawson discussed that a current audit of 2WW forms showed that 85% were not completed or indicated that suspected cancer was discussed. This issue will need further review at the board next time.
Conclusion	Board member to review and provide comments
Actions and responsibility	**Update to be sent to Sarah Taylor, any update will be brought back to the board.**

6. Greater Manchester Cancer plan: Neil Bayman/ COR

Discussion summary	**Greater Manchester Cancer plan update:** NB discussed the plan it has been widely distributed 6 main objectives.
Conclusion	**Final plan signed off and agreed for distribution.**
Actions & responsibility	**All board members requested to review and agreed actions**

7. TNM staging: letter and discussion Neil Bayman.

Discussion summary	**TNM staging:** version 8 released. NLCA/ summerset, highlighted that there will now be a delay in its inception until 2018. Still expected to update data on version 7, board members discussed that we don't want to use 2 versions due to increase in risk. NB discussed the need for a consensus on this, RB discussed that UHSM are using version 8. Lots of debate with board members.
Conclusion	**NB discussed a network wide response. Don't want to risk contamination of both systems. We should be using version 8 but no clear plan. Board members agreed in principle to all use version 8?**
Actions & responsibility	**All board members will be emailed to canvas opinions.** **NB to write to lung Cancer audit team to request a final plan on this.** **Require update at the next board meeting by NB.**

8. Pathology Subgroup update: Leena Joseph/ Anne Marie Quinn

Discussion summary	LJ discussed the unified proforma that has been completed, so there will be GM working group, for lung biopsy and cytology specimens. There will be a process to standardising the approach across GM. There is a wealth of information on GMCancer website and a posters at BTOG. NB congratulated the team on the work completed so far. Process and proforma will be discussed at research event on the 17th March. AQ discussed the standard pathway for SCLC, discussed survey 12 pathologist, most preferred to use 4 immuno-markers instead of 2, for SCLC, when panel is negative they do not want to wait for MDT, pressure for turnaround time. Everyone is incorporating molecular testing into the results, 9/12 pathologists surveyed are doing reflex testing, so there is variation with regards to reflex. Group is working through variations. DR, critically to new proforma reporting from the colleges. Meet to decide where the proforma goes, particularly on the small samples.
Conclusion	**Excellent work and working group to continue to provide update to pathway board.**
Actions & responsibility	**Need to agree the format, discussions to take place at the 17th march education event.**

9. **Faster and Better Diagnosis**-Chair Richard Booton

Discussion summary	RB discussed the 3 core objectives, • First objective largely pre clinic information to CT reporting • Second objective follow on investigation i.e. PET CT / EBUS etc. • What currently exists/ Staffing models in key service areas i.e. radiology.
Conclusion	**Data is essential now to assess impact of this piece of work, RB to liaise to LG-D to review data- set**
Actions & responsibility	**RB to find which of these objectives can be received from the existing data. If this is available RB and team will present at the next board.**

	If we don't have data need to come up with information before the next board meeting.

10. Improved and standardised care: David Woolf and Mr K Rammohan

Discussion summary	**DW summaries on behalf of the sub-group.** Main standard discussed was Decision to treat (DTT) 85% of patients within 14 days (calendar). 3 core objectives have been discussed: • Understanding the gap • Formulation of algorithms • Implementation of this. Key discussion points, Define what step DTT date is made, this should be at the MDT (not always the consistent approach here). i.e. surgery/ first fraction of XRT or first cycle of chemo. Look at data in place to support this. • Look at the gaps, by stage of patient. What is the current pathway is?. • Diagnostic Algorithms, original CT and fitness of the patient which will inform the MDT decision. • Second group are treatment algorithms which will be broken up by stage of patients as to the algorithm which will inform treatment decisions from MDT. Need to be complete so that all this information can be brought to the MDT. • Time frame for this is the next 3 months to have full draft algorithms in, work already done by ME on this, team with work on these current algorithms. • Implementation will involve a pilot potentially. Gap analysis and resourcing is key. Implementation could take 6-12 months?
Conclusion	**Key themes were agreed and actions as above.**
Actions & responsibility	**Gap analysis would be 6 month time links and clear plan on data?** **Molecular pathway data was discussed.** **What the current guidance is saying-MDT or discussion with the patient? Need to confirm.** **Infrastructural changes will need to be made to deliver this.** **All team members will be involved in algorithm review.**

11. Living with and Beyond Cancer: Chair Carol Diver

Discussion summary	CD discussed that critical to delivery of the LWBC agenda was a review of CNS ratios (stipulated 1:80) and scoping an audit/ questionnaire to CNS teams. CD to produce a survey to send out to all CNS teams and organise an evening meeting. Recovery package and HNA-Ipad's not the best way forward for patients and

	staff, who and where. And all other elements of the recovery package need to be reviewed. Follow up care: CD discussed Matt Evison work, she will contact Matt to get information on protocols and algorithms. Lung cancer study day discussion of this with posters and initiatives on services. Treatment summaries, differences across different sites and in surgery it is not happening at all-must review this as a matter of urgency.
Conclusion	**Essential to review survivorship protocols/ working along with recovery package to deliver all aspects of this.**
Actions & responsibility	**April: feedback from survey** **Over view of update** **FU pathway and protocols. CD to chase ME to get more information and understanding. ME runs a survivorship FU/ risk stratified information needs sharing. ME will share data on lung cancer resections.** **Cancer plan and LWBC important part of the cancer plan on LWBC board.**

7. Any other business

- All agenda items not discussed will be brought to next meeting.

8. Date and time of next meeting

Friday 28th April 14.00 – 17.00hrs

Holt Major room, Patterson research institute, Christie hospital.

Meeting dates proposed 2017:

- **12.07.17:** 14.00 – 17.00hrs Christie
- **06.10.17:** 14.00-17.00hrs Christie