# GYNAECOLOGICAL PATHWAY BOARD MEETING

## MINUTES

## DATE: 06/03/2015

**Member's attendance:**

| | | | |
|---|---|---|---|
| Dr Barraclough (Chair) | Christie | Mr Suku George | Stockport |
| Miss Catherine Holland | Central | Mrs Vanessa Hilton-Watts | Macclesfield |
| Mr S Burns | WWL | Mr Kyle Gilmour | Tameside |
| Julie Dale | Pennine | Dr Richard Hale | Stockport |
| Karen Johnson | Christie | Dr Andrew Clamp | Christie |
| Dr Mike Smith | Christie | Dr Ann Mills | Bolton |
| Sabina Frocan Wood | UHSM | Julie Kiernan | UHSM |
| Julie Dale | Pennine | | |

**In attendance**

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| Hodan Noor | Manchester cancer |

**Apologies**

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| Dr Susan Davidson | Christie | Mr Rick Clayton | Central |
| Mr Richard Slade | Christie | Mr S Ali | Pennine |
| Mr Murray Luckas | Leighton | Debbie Beadle | Tameside |
| Mr Vincent Hall | Macclesfield | Mr Brett Winter-Roach | Christie |
| Karen Blackwood | WWL | Ann Lowry | Central |
| Ms Jo Dzyra | Stockport | Mrs Sally Petith | Leighton |
| Mr K A Abidogun | Bolton | Amanda Lowe | Tameside |

- **Welcome, introductions and apologies**

Dr Barraclough (LB) welcomed all to the meeting and noted the apologies received. She also informed the group Amanda Lowe has replaced Deborah Beadle from Tameside.

- **Minutes of the last meeting and matters arising not on the agenda**

These were noted as an accurate record of the meeting by members of the board.

a. Matters arising not on the agenda

i. <u>MDT Technology support and upgrade</u>
JL confirmed that this item has been put onto the Cancer leads meeting of Manchester cancer to be held on 12th January. This item was differed to the next meeting for JL to update members.

ii. <u>NCRN research nurse establishment</u>
Deferred until next meeting

iii. <u>Patient representative (was not discussed at the meeting)</u>
The board recognised that there were still no patient representatives on the board. HN informed the board of the Manchester Cancer plans for patient involvement. The board were asked to try and identify and nominate any suitable patients.

IV. Guidelines review

Dr Mills updated members the Radiology members from Christie and CMFT have met for a review of SMDT following all the recent changes. They also discussed the guidelines and Dr Suku from UHSM gave a talk on the management of incidental findings on abdominal CT and MR. The group will be meeting biannually, members discussed the benefit in inviting all radiologists involved in the Gynaecology pathway to be included in the meetings to support standardised guidelines across the network.

Action:DR Mills will discuss including all radiologists at the next meeting.

V. Draft SMDT standards

Action: LB to develop joint SMDT standards amalgamating UHSM and CMFT documents to ensure common operational delivery of SMDTs.

**Agenda**

1. **Objective no 1 – Improving outcomes /survival rates**
   - Guideline review

The 2012 guideline document was tabled and a discussion was held on how to the review the document. It was agreed that the surgical, medical and clinical oncology would be reviewed separately by subject specialists.

**a. Pathology**

Pathology input is needed in the development of the guidelines, distinction between histology type specific high or low grade cervix for example in management of ovarian cancer and complex cases, in order to reduce variability.

Action: Pathology meeting is due to be scheduled RH will feedback on the outcome of the meeting.

**b. Nursing**

Nursing support guidelines was scheduled to be discussed at the way day which has now been postponed, alteration has been made and will be shared once team have fed back.

**c. Radiology**

Dr Mills shared an update made from radiology perspective of the guidelines for management of gynaecological cancers.

1.4 Remove statement: If central pelvic recurrence is considered salvageable by MRI then PET should be performed. Agreed by members.

1.10 Fistulae instead of CT scan change to MR Scan, to assess with a view to surgical management. Agreed by members.

3.0 to 3.4 endometrial cancer. Imaging needs to be discussed further with the surgical members to ensure this supports surgical management with reference to the national guidelines for endometrial cancer management.

The limitations include restricted local MR facility for people with early endometrial patients (1a and 1b).

Members proposed a retrospective audit, cohort of patients to identify the proportion as a result of MR scan had significant change in their care plan.

Action: Dr Mills will propose possible audit to the radiology team.

3.13 prognosis is far more favourable for central mucosal disease:- change to central pelvic disease.

4.4 ovarian cancer box for initial diagnosis: the need to include CT thorax? After much discussion the group agreed an audit is needed to identify the benefit of CT thorax at the initial diagnosis stage prior to making changes to the guidelines.

4.14 In young patients with stage I disease, fertility-sparing surgery can be considered. In mucinous borderline tumours, particularly those associated with mucinous ascites (pseudomyxoma peritonei) or extension outside of the ovary, appendicectomy should be performed. This to be reviewed by and responded to by surgery guidelines for feedback since this has been updated nationally.

5.3.1 Under staging - surgery guidelines review to provide standard of investigation required to support peripheral hospital who undertake imaging.

5.8.1 Sentinel node dissection in vulval melanomas has been explored with encouraging results but is currently performed only within the context of clinical trials. CT of chest, abdomen (including dual phase CT of liver for hypervascular metastases) and pelvis are performed to exclude widely metastatic disease. Agreed by members.

8.2.6 In the absence of clinical evidence of active disease, change CT Scan to an MRI scan should be performed to assess with a view to surgical management. Agreed by members.

**d. Radiotherapy**

LB updated radiotherapy changes in treatment in the management of gynaecological cancers guidelines.

LB proposed further changes with regards to follow-up as follows;

1. Endometrial cancer patients who have had surgery, chemo and pelvic radiotherapy - could we see them 12 monthly and alternate with surgeons for three years – with a view to make sure they don't run into trouble with treatment effects and ask the gynaecologists for further follow-up and give them our open follow up leaflet?
2. Endometrial cancer patients who have surgery and then brachy only - see once and ask the surgeons to continue follow-up to 5 years – a few will relapse within the pelvis and be referred back. Patients who received chemotherapy only and no radiotherapy or brachytherapy to return to referring surgen for follow-up.
3. Post op vulva - see once and refer back to surgeons – they seem to not have the same problems with bowels as the pelvic RT patients
4. Post op cervix see 12 monthly and alternate with surgeons for three years like the endometrial patients who have had RT.
5. Primary cervix and vagina patients - we follow up as we do now with all their issues.
6. Primary vulva share FU with surgeons

It was agreed guidelines need to be development jointly with Surgical, Radiology and Pathology to ensure clinical decisions are supported by the guidelines accordingly once all amendments have been made to be shared across disciplines.

Action: LB to share all the proposed changes to the members of the board
Dr Mills to share all changes of the radiology guideline amendments to the board members.

- Final Report on CWP Gyne MDT Pilot

The report was shared by members on the pilot project, from a surgery perspective there is a need to see the outcomes data has been raised as a benefit to understand the need for using CWP rather than replicating the role of Somerset which primary reports on performance.

There is also a need from a surgical perspective to replicate some of the work Somerset currently collates such as tracking, follow ups and patient notes. Members queried can CWP be used as a real time electronic patient record which can be updated at clinic with the patients, LB confirmed this functionality is available. Work on including a tracking function in CWP is under discussion.

The benefits of using the CWP also will support having a standardised tool for assessing comorbidities which will provide a consistent approach to analysing data effectively.

The concerns for members involved in the pilot has been because the MDT forms has been changed this does not include target dates of treatment and this has an impact on waiting times.

Members also queried the opportunity of using CWP for all operational activity and clinical outcome dual populating information into two systems has created further workload without increase in capacity.

HN described the Trusts engaged is Somerset at tied up in a contractual arrangement and moving solely to CWP will take time and interest from the providers, however there is an opportunity to query with the clinical outcome unit developing CWP the opportunity for interoperability system which can extrapolate Somerset data into CWP.

Data protection is a query and concern having the ability to access all patients' data, LB confirmed that the access levels will be set to match the area of work and referring Trust.
The pilot paper needs to be amended not all patients are Christie patient, with regards to data ownership this data will be owned by Manchester Cancer.

Actions: JL request the incorporation of target date field to be included in the Performa. Arrange presentation on outcome data for Gynaecology to be presented at the next meeting.

- Cervical Cancer ONS 1 & 5 year survival report

Was shared for information
LB updated members on meeting with Public Health to build relationships with school nursing and screening programmes to provide education and awareness to improve screening uptake and HVP vaccinations.

2. **Objective no 2 - Improving the patient experience**
   - <u>Local Patient experience survey</u>

JK updated members on the patient experiences survey, Christie has started on the survey for patients who have had surgery in January 2015. There is a benefit to share the tool at the nursing meeting to replicate this audit in the respective Trusts.

3. **Objective no 3 – Research and innovation**
   - <u>Research update report</u>

The proposed date for the research meeting was agreed to be the 22nd of May, AC will lead on medical oncology SD leading on clinical oncology and RS potentially to lead the surgery. Attendees include unit leads, radiologist, pathologies, CNS, research nurses, medical and clinical oncologist etc.

Although we have sponsors, a proposed agenda including tiles are requires for our sponsors to support this education meeting.
Actions: LB asked members to share the presentation titles with JL

LB shared with members prostate pathway have had open forum meeting and asked members would this be useful for this board to see what the work of the pathway is. Members did not see this being a useful for members however if there is a need to share information this can been discussed at MDT and steering groups organised more locally.

- **Improving service delivery**

Update on single service project
LB proposed the delivery of care should not move from single service and there is still opportunity to work towards a more single service approach this will be discussed further and will be shared at the next meeting.

- **Any other business**

Annual report template for 2015 to be discussed at the next meeting

**4. Date & Venues for next meeting**

The proposed dates for meetings in 2015 are below.

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| **1st May 2015** | **14.00 - 16.00** | **CMFT** |
| **3rd July 2015** | **14.00 – 16.00** | **Christie** |
| **4th September 2015** | **14.00 – 16.00** | **CMFT** |
| **6th November 2015** | **14.00 – 16.00** | **Christie** |