Haematological Oncology Pathway Board

Thursday 23rd April 2015, 3pm – 5pm, HTU Seminar Room, the Christie

Attendance	
Name	**Pathway Representation**
Mike Dennis	Chair
Hayley Greenfield	Pennine Representative
Clare Barnes	Salford Representative
Jo Tomlins	Nursing and Christie Representative
Eleni Tholouli	CMFT Representative
John Hudson	East Cheshire Trust Representative
Simon Watt	UHSM Representative
Hitesh Patel	WWL Representative
Montaser Haj	Stockport Representative
Jane Woodward	Patient representative
Liz Bates	Patient representative
Sue Dyde	
Melissa Wright	Pathway Manager
Apologies	
Name	
Beth Chalfin	Specialist Physiotherapy Haematology
Hussein Baden	Tameside Trust Representative
Suzanne Roberts	Bolton Representative

Agenda Item	Action
1. Welcome and Introductions MD welcomed everyone to the Pathway Board meeting and introductions were made. Apologies were noted.	
2. Minutes of the last meeting Item 4 (c) GP Education event. MD asked for two clinical representatives to support the Christie School of Oncology event to be held on the afternoon of 18th November. HP agreed to support this event and LB agreed to volunteer as a patient representative and to identify a GP facilitator **ACTION:** **MD to identify a further clinical representative** **MW to confirm with representatives with the School of Oncology** Item 6 (a) MD confirmed the position regarding AML excess treatment costs which had been communicated via letter by NHS England.	 **MD** **MW**
3. Manchester Cancer Objective 1 (a) Improving surgical access- presentation from Pennine on 2WW HG explained that the Pennine were asked to review their GP 2WW referrals as the Board had some concerns that many of these were inappropriate. The audit reviewed 56 patients and the patients' notes and clinic letters were used to attain the data. All patients were seen within 14 days and 19 were confirmed as having a malignant diagnosis (32%), with one not being a haematological malignancy. Of these patients 95% were treated within 62 days. 50% of all patients were <50 however most of the patients with a malignancy were not in this age group. Of the patients with a haematological malignancy only 33% required active treatment. HG felt that on balance 63% of patients referred were done so appropriately. HG indicated that on 43% of patients referred no suspected diagnosis was listed by the referring GP. Lymphadenopathy was the diagnosis for 12 patients and lymph node biopsies were undertaken on eight of these patients, many of these undertaken on the younger patients. HG feels that Pennine over-investigated this group of patients and will take this feedback to her department. MD asked if any other Trusts wanted to review their 2WW data and SW indicated that he has a list of patients but hadn't gone through the data yet. LB explained that there would be a national audit of 2WW data. (b) Review of 2WW referral forms MW had received the 2WW referral templates from most Trusts and identified that they were similarities across most of them. LB explained that the RCGP are looking to provide a national template for 2WW referral forms.	
4. Objective number 2 – Improving the patient experience (a) Specialist Nursing Group Update JT explained that the next meeting will take place on the 7th May and the focus of the meeting will be around the National Patient Experience Survey. JT undertook a specialist nurses survey and the results indicated that there was a similar resource across all Trusts apart from CMFT who have 4.4	

WTE. JT also indicated that Tameside would be losing their CNS shortly. HG explained that following MD letter to the Trust Cancer Lead, a meeting has been arranged with the Operational Manager at Pennine regarding nursing capacity next week to address their nursing capacity. MH highlighted the lack of SCN resource would be considered a risk to smaller units in undertaking certain cancer therapies which would result in patients being referred to larger units for treatment. (b) Patient Communication Survey CB indicated that she has received eight responses. All but one responder indicated that MDT decisions would be fedback to patients. CB confirmed that this question might be more relevant for newly diagnosed patients within acute Trusts. MH indicated that he writes to all patients following the MDT on the decisions made however ET identified that this may be difficult for Trusts managing a high number of patients. HG asked whether patients should be told that they will be discussed at an MDT. LB thought it would be useful to ask whether a patient would like to know this information and CB felt that a lot would depend on the diagnosis and treatment plans. CB explained that feedback was made through both phone calls and letters and communication took place within a week or at the next clinic appointment. CB thought it would be useful to explore what patients wanted. JW explained that she conducted a patient survey at Manchester Royal Infirmary and communication with patient regarding treatment decisions was highlighted as a key issue. **ACTION:** **MD to contact London Cancer to assess their level of SCN resource** **MW to raise this issue with Manchester Cancer user involvement Team in liaison with JT**	 **MD** **MW**
5. Objective 3 – Research and clinical innovation (a) Network resource trials resource update SW explained that he attended a NIHR meeting in London where improving recruitment was discussed. It was felt that trial maps could be implemented nationally with data provided for every region and there should be a core portfolio of trials available to each MDT. (b) Review of Trust activity SW explained that the region was recruiting well and the Network was currently 9th nationally. The region was better at recruiting interventional trials than observational trials. SW highlighted that many regions have recruited into registration studies. MD felt that the decision regarding these studies should be taken by individual trials teams rather than agreed at a network level. SW noted that there was a variance in the numbers recruited for certain trials by each Trusts and it was reflected that this was due to patient choice and the capacity within each Trusts to support rigorous trials. HP noted that WWL were not included in the Trust activity and this was due to there being no recruitment this year due to their issues with pharmacy. SD agreed to liaise with SW in regards to highlighting when new trials are open and where they are available. SD indicated that she is trying to persuade the NIHR to offer trials at network level and opened at individual centres following local agreement. SD explained that Trusts can be linked with another site via the pick site methods, which will allow more income to be generated for commercial trials.	

(c) Delivery of chemotherapy for haematology at WWL A meeting had taken place with the lead trials nurse and chief pharmacist at WWL as well as the lead pharmacist at the Christie to work through options to resolve the pharmacy which are specifically impacting drugs in IV form. These included looking into purchasing a unit to reconstitute drugs and developing the working relationship with the pharmacists at the Christie as well as reviewing the option of electronic prescribing. (d) National research capacity data MD explained that data was not yet available, however there would be an open invitation for all centres to become apply to become Therapy Accelerated Programme centre, which could provide a route to increased trials resource **ACTION:** **SD to identify the level of funding for each Trust in regards to research** **SD to communicate with SW regarding trials that are opening**	 **SD** **SD**
6. Objective 4 – Improving and standardising high quality care across the whole service (a) Progress on HMDS Partnership MD explained that it had been agreed that John Burthem would be the Chair and Adrian Bloor would be Vice Chair. The Board agreed that they would want a formal report to the Pathway Board following each meeting. MD explained that terms of reference for HMDS steering group were proposed and had highlighted potential membership from each Trust. It was noted that many Board members had not been contacted individually regarding their potential membership. (b) Peer Review Trust measures MW explained that Manchester Cancer core team had produced local guidance to support Trusts through the Peer Review process and that Trusts who wanted to discuss any MDT level clinical data could do so at this meeting. HG queried some of the MDT measure regarding following network level clinical pathways. (c) Review of the Christies capacity audit JT explained that the first four standards are the key items for the capacity audit. The Christie also chose to look at 30-day mortality for the high intensity patient group and compared the information with last years' performance. The audit highlighted that the numbers of patients were similar to the previous year. Majority of admissions were made following a hotline call. Two patients were admitted to a local A&E due to lack of bed availability. The recommendations focused around developing efficiency around bed management. MD asked whether the other Trusts required to complete capacity audits could prepare them for the August meeting (d) Development of clinical guidelines MD highlighted that all the guidelines required for Peer Review will be available on Manchester Cancers website. In regards to CLL and Lymphoma, MD explained that the lead authors have	

indicated that they will not be updating their guidelines but will refer to the national guidance. There was limited support for this position by the Board and it was suggested that members of the Board could be involved in the updating of the local guidelines. In regards to AML and MDS will be updated in time for Peer Review. (e) Stem cell transplantation ET explained that she has spoken with the London organiser regarding the EMBT and Manchester Transplant will be indicating an expression of interest by the end of July. (f) TYA No updates for this meeting **ACTION:** **MD to liaise with John Burthem regarding formation of the HMDS group** **HG to send MW the operational policy and highlight MDT agreed measures that require network input** **Capacity audits to be reviewed at August meeting** **MD to contact the authors of CLL and Lymphoma to represent the views of the Board**	 **MD** **HG** **Trust reps** **MD**
7. A.O.B (a) Improving Outcomes guidance MW explained that NICE currently have this document out for consultation with the closing date of next week. Any comments regarding the guidance can be sent to MW as Manchester Cancer has registered as a stakeholder. (b) Haem-Onc Annual Report MW explained that Manchester Cancer will be reviewing their Annual Report and the chapter headlines and summaries will be sent out with the minutes. Members who feel they would like to, are invited to contribute to the report. (c) NCRI Annual Trials Review meeting SW has forwarded information regarding this event which will be take place on 2nd June (d) Acute Oncology ET feels that the acute oncology team were not providing adequate support for her department. (e) Clinical web portal pilot MD confirmed that the South pilot should be rolled out in May following negotiations in regards to information governance issues. (f) Living with and Beyond Cancer representative for the Board MD asked whether the Board was happy to for Rowena Thomas-Dewing to attend the Board in her role as lead for this area of work. MW explained that she had met with Rowena who had already begun mapping current survivorship initiatives across the region. The Board agreed that they were happy for her to attend. **ACTION:** **MD to discuss acute oncology support with Pathway Director**	**MD**

MD to confirm the implementation of CWP with Jac Livsey	MD
8. Date of next meeting - 25th June 3pm – 5pm 2015 Palatine Treatment Centre Seminar Room, the Christie	