

**Haematological Oncology Pathway Board**

Thursday 19<sup>th</sup> December 2014, 3pm – 5pm, HTU Seminar Room, the Christie

<b>Attendance</b>	
<b>Name</b>	<b>Pathway Representation</b>
Mike Dennis	Chair
Suzanne Roberts	Bolton Representative (incoming)
Clare Barnes	Bolton Representative (outgoing)
Jo Tomlins	Nursing and Christie Representative
Eleni Tholouli	CMFT Representative
Hayley Greenfield	Pennine Representative
Hussein Baden	Tameside Trust Representative
Simon Jowitt	Salford Representative
Simon Watt	UHSM Representative
Hitesh Patel	WWL Representative
Montaser Haj	Stockport Representative
Liz Bates	Patient representative
John Radford	The Christie
Richard Byers	CMFT
Melissa Wright	Pathway Board Manager
<b>Apologies</b>	
<b>Name</b>	
John Hudson	East Cheshire Trust Representative
Jane Woodward	Patient representative

Agenda Item	Action
<p>1. Welcome and Introductions</p> <p>MD welcomed everyone to the Pathway Board meeting and introductions were made. MD also explained that he had been approached by University representatives from the Christie and CMFT to discuss HMDS and he felt that their attendance for that item would be reasonable.</p> <p>MD also welcomed SR from Bolton to the Board, she will now replace CB as the Trust representative, who will be moving on to a Salford.</p>	
<p>2. Apologies</p> <p>Apologies were noted.</p>	
<p>3. Minutes of the last meeting</p> <p>Item 3: Presentation of the Clinical Outcomes Portal – HG explained that Pennine did use the Somerset system, however had also created their own online proforma. LB asked where data regarding ‘a patient first experiencing symptoms’ was going to be accessed from and whether the date the patient first presented to their GP could be included as an additional field. MD recognised that this would be important to differentiate but was keen to ensure that any dataset developed struck the balance between being meaningful but not too elaborate.</p> <p>Item 14: Patient Communication - <b>Clare Barnes will be sending out a questionnaire to all Trusts.</b></p>	<p>CB</p>
<p>4. Manchester Cancer Objective 1 - Improving Outcomes/survival rates</p> <p>ET explained that CMFT had managed 17 cases within a quarter, the majority of which were not true lymphoma or cancer cases. Once a referral to haematology was made, patients were seen quickly, and the delays occurred when patients were referred for lymph node biopsies that were not ENT as these patients were going back and forth between departments. The timelines to ensure there was not a breach generally occurred in patients who entered via another speciality.</p> <p>HG discussed the cases that were managed by Pennine within a three month time frame. In all there were 52 cases of which 40 had been recorded onto the template. There was an 18 – 20% cancer conversion rate from cases referred via the GP’s for haematological cancers with a small percentage being positive for other cancers. . HG indicated her Trust cancer manager explained that this conversion rate was slightly higher than for solid tumours which were around 10%.</p> <p>LB explained that current NICE guidelines for GP’s on 2WW referrals are based on a 5% conversion rate and the new NICE guidelines that are currently out for consultation will look to lower this threshold to 3%. This may result in more patients coming into secondary care via a 2WW referral that may not have cancer. LB explained that this should encourage communication between secondary and primary care to evaluate any resulting changes to referral patterns. MH explained that his Trust was not allowed to drop a 2WW referred patient if it was not felt to be an appropriate referral. SJ explained that this could be done following a conversation with the referring GP.</p> <p>HG queried the inclusion criteria of cases for this data and asked whether low level cancers should be identified as an inappropriate referral as no treatment would be needed.</p>	

<p><b>ACTION:</b>  <b>Pennine data to be reviewed once analysis is completed</b>  <b>All cancers to be counted but grouped into those needing/not needing treatment</b>  <b>LB to send Board new NICE guidance on haematological oncology symptoms</b></p>	<p>HG  HG  LB</p>
<p>5. Objective number 4 – Improving and standardising high quality care across the whole service</p> <p>a. Update from HMDS meeting</p> <p>MD explained that the development of a local HMDS is a key objective of this Pathway Board and this has been explored in recent months including two separate sub-group meetings involving a wider group of stakeholders. At these meetings it was agreed that the HMDS needed to be NICE Improving Outcome Guidance (IOG) compliant, provide a quality service and preserved the opportunity for local education and research. MD identified that he had been approached at short notice by JR and RB to attend to support the progress of these discussions. MD reflected that from the three proposals presented, the proposal from CMFT/Leeds was far more developed and specific regarding the operational development of the service. MD highlighted that he was disappointed in the current position that would not easily facilitate Greater Manchester developing an in-house provision and wasn't clear whether the current front running proposal was an inclusion of all provider Trusts as not all had been referenced as doing so within the proposal (East Cheshire and the Christie). MD questioned whether there would be the same opportunities to engage in research and education with a service that is not fully based within the region.</p> <p>HG has spoken to all of her histopathology and haematology colleagues at Pennine and had gone through all of the proposals and is confident that her Trust supports the CMFT/Leeds bid. CB took on board MD comments but felt that many on the Board could not envisage setting up a HMDS in Manchester in isolation. CB felt that the Christie proposal did not have enough substance to be a credible contender and meet the needs of her patients and thought the research and education element of the service would develop alongside the development of the HMDS.</p> <p>MW asked whether the consultation that had taken place at Pennine had taken place within all Trusts. SJ thought that this would be important to determine and felt that the managers within his Trusts would want additional clarity on costs, turnaround times and quality. MH explained that his Trust will be developing a Quality Board and he intends to take the HMDS proposals to this in the anticipation that clarity regarding costs and quality would follow. MW thought it would be important to get this clarity to ensure any agreed proposal would get the agreement at Provider Board level. ET thought that the rationale for the HMDS were clearly laid out within the CMFT/Leeds proposal and MW thought that this should be communicated to the Provider Board while work went on to refine and develop a proposal.</p> <p>JR felt that there should be some principles leading this discussion. These included providing a service across Manchester consistent with Manchester Cancers' ambition of clinical engagement and working together and providing an excellent service to all that is timely and affordable. JR felt that the current situation wasn't working well, but it would be important to reflect on how the relationship with Leeds would be formulated. JR thought it would be better to develop a collaborative relationship and match that with building capacity and capability within Manchester. JR also thought that any plan for the development of the service should be appropriate for everyone. JR referenced a couple of projects that have recently been developed in partnership</p>	

with the Christie and CMFT and wondered whether there was an opportunity to build a service that was fit for purpose, that is collaborative with Leeds and centres in Manchester but didn't degrade the expertise that already exists. JR thought this might be best done by dividing up the region to create a 'Trans Pennine HMDS' brand. Having spoken within representatives at Leeds, JR indicated that they are very keen to collaborate but would not want to be part of a fragmented service.

ET felt that the current proposal was in an advanced state and that it was important to move forward quickly, the current position was a disaster for most Trusts and that the Christie was in a different situation regarding diagnostic provision. ET didn't feel that there was anything stopping the development of a Trans Pennine service and this could be developed as part of the CMFT/Leeds proposal. CB felt that it was important not to go back on current progress and try and develop a further proposal. She explained that the last HMDS meeting was where both the Christie and CMFT were given the opportunity to identify their plans for developing a service and from that meeting it was clear that the CMFT proposal had received the majority of support.

RB felt that there were merits in both proposals. The CMFT/Leeds proposal would be able to get off the ground sooner which would be agreeable to most Trusts. RB felt that the Christie/Synlab proposal lacked detail and doubted that the organisation could meet the financial risk of around £2-3 million a year. RB and JR have spoken regarding this prior to the meeting and RB identified that his ideal would be a combined solution with the Christie and CMFT working together. It would require good will and new ways of working and would need to include Leeds to be viable. RB accepted that to move forward with the current CMFT/Leeds proposal could cause an element of fragmentation to the haematological reporting and it would be important to try to avoid this, but reflected that a combined solution may result in friction between the two haematological departments. JR suggested using the CMFT/Leeds proposal as a template and dividing the work between the two sites as a starting point. This could be supported by detailed contractual arrangements. ET suggested that members of the meeting vote on which proposal they would like to move forward with as she was concerned that discussions regarding a revised service model would incur further delay to moving the process forward. JR suggested that the members look clearly at what is required and how the Board would see this being delivered. RB identified that it would be challenging to develop a model of service that incorporates the Christie/Synlab partnership as they are a private organisation and would want to move towards developing a service led by CMFT/Leeds which would involve the Christie working alongside.

CB expressed concern regarding splitting the service across two sites within Manchester. HG clarified that although this project would be managed and based at CMFT, it would be a collaborative project and as such owned by all within the region that have expressed a desire to buy into it. She reflected that she had colleagues at Pennine who would be interested in undertaking sessions at CMFT and felt this would be the case across the region. MH noted that the proposal put a lot of emphasis on the working and contractual relationship with Leeds but there was less information on how the centres within Greater Manchester would work together. MD reflected that there was a lot of drive to move forward on the work that had taken place within the last six months and it would be useful to expand the proposal to reflect all the Trusts involved. MD felt this was a key opportunity to demonstrate to the Manchester Cancer Provider Board that the clinical community were committed to a unified approach. JR felt it was important that the service incorporated all of the expertise and the capacity and capability that are currently available and as such the involvement of the Christie should be made clearer within the proposal. JR gave the

<p>specific example of the Oncology Cytogenetic service for Greater Manchester which is currently based at the Christie.</p> <p>RB summarised that he thought the best way forward would be to adopt the CMFT/Leeds proposal with the Christie working with CMFT in the same way as the other centres would. He also suggested that the service could be described as the Manchester Cancer Diagnostic Service to demonstrate the inclusion of all centres in the service. HG felt that this proposal would be unanimous across the haematological community. SJ thought it would be important to identify the opportunities Synlab could bring to support any additional resources required for this service model. JR explained that the partnership with Synlab has allowed the Christie to develop their capital projects and thought that these opportunities should be explored before committing to any proposal. CB felt that the service developed within the new proposal would negate the using of the Christie Pathology Partnership and identified that following a review of what is currently reported locally there would not be a significant cost increase to Bolton to have these reports performed within Leeds. HG noted that there may be savings made on the lymph node biopsies but an increase costs for the aspirate and trephine work required by Pennine. She also explained that double reporting was not currently taking place within Pennine and the CMFT/Leeds service model would support this. MW thought that this level of detail on financial implications for each Trust would be useful as part of developing the proposal and to present to the Provider Board. CB reflected that all Trusts would need to develop integrated reporting to become IOG compliant and that would inevitably increase the costs.</p> <p>LB asked what the impact would be on patients if an agreement was not made regarding the way forward. MD explained that at present there is a quality service provided by a variety of laboratories to Greater Manchester e.g. from Leeds but this is not integrated. The clinical members all felt that a service model where all samples were sent to the same place and double reported would ensure consistency of service and IOG compliance. MD noted the support expressed but identified that this could incur issues for the Christie with potential deterioration in short term provision. MW suggested presenting a brief report from the Pathway Board on what had been discussed and agreed at the meeting and the plans going forward. HG suggested that the proposal from CMFT/Leeds could be presented to the Provider Board as it clearly presents the background and the proposed way forward. MD identified that both East Cheshire and the Christie had not been named on the proposal in regards to supporting it and with paper only being circulated very late last night representatives have not had sufficient time to consult all colleagues. JR added that as a major cancer centre in Manchester, the Christie had to be appropriately reflected in the service model proposed. HG explained that Pennine also undertook a significant amount of haematological oncology and considered the Christie as an equal partner and as an acute Trust, was more aware of the needs of a wider representation of haematology patients requiring diagnostic services. JT identified that as a Christie representative she acknowledged that there was a lot of support from Christie consultants for a collaborative approach across the region.</p> <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li>• <b>The outline/principle of the proposal presented by CMFT/Leeds to be presented to the Manchester Cancer Provider Board.</b></li> <li>• <b>Service would be described as Manchester Cancer HMDS</b></li> <li>• <b>Further work to be undertaken by CMFT/Leeds/all Manchester Cancer Trusts to assess quality/financial implications of current provision and potential configuration of proposed service</b></li> </ul>	<p>MW/MD</p> <p>CMFT/Leeds/All Trust representatives</p>
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<p>b. 2014-15 Cancer Wait data</p> <p>MW explained that access to 31-day diagnosis of cancer to first cancer treatment and 62-day urgent GP referral to first cancer treatment data was now available to the Board through the Strategic Clinical Network and had been sent to all members along with the 2 week wait data for Q1 and 2 of 2014-15. MW explained that in regards to 2WW and the 31-day all Trusts seem to be performing well, but there were some issues for some Trusts in regards to the 62-day target. MD thought that it would be important for Trusts to review this data with their cancer managers</p> <p>c. Development of clinical guidelines</p> <p>MD indicated that the MDS and AML guidelines were out of date and a meeting has been arranged for 16<sup>th</sup> January to update both guidelines.</p> <p>d. Stem Cell Transplantation</p> <p>ET informed the meeting that she has been involved in a bid with Dr Adrian Bloor to host the EBMT at Manchester in 2019, further information will be provided on the progress of the bid. It was suggested that Prof Rob Wynne was also invited to participate.</p> <p>e. Teenagers and Young Adults</p> <p>HG explained that Louse Pennington the TYA nurse had agreed to attend the next meeting.</p>	
<p>6. Objective 2 – Improving the patient experience</p> <p>a. National Cancer Patient Experience Survey 2014</p> <p>MD explained that this data had been sent to all members for information. The survey is sent to all cancer patients admitted to an NHS hospital as an inpatient or day case during 1<sup>st</sup> September – 30<sup>th</sup> November. Each patient was sent a postal copy to their address following their discharge and up to two reminders were sent to non-responders. MW explained that the questions shaded in yellow had been identified by the Greater Manchester PUP group and these would be specifically monitored by the Provider Board. Responses of less than 20 patients within a tumour group from a Trust would not be included in the site specific analysis. CB highlighted that Bolton did not perform well in regards to the question regarding financial help and opportunities for research. LB indicated that there are some concerns as to whether patients were always able to understand some of the questions and ET felt that this was true specifically in reference to research. In regards patient responses from CMFT, the main issue was social work support but this has been impacted because of staff changes. ET explained that in relation to the question regarding contacting the CNS, CMFT now have a CNS administrator who takes phone calls from patients. ET thought some of the data presented within the report was different to the survey results that she has received.</p> <p>HG reflected that Pennine’s performance in regards to the NCPES had been getting worse over the last 3 years. This related to the two-tier system within Pennine and the lack of CNS support. For patients with cancer who need treatment feel that they receive an excellent level of care, for patients with earlier stage cancers their level of treatment is significantly different and is reflected</p>	

<p>in their survey results. CB felt that the patients at Bolton who are new to follow-up do not receive a service equitable to patients being treated.</p> <p><b>ACTION:</b>  <b>Patient experience data to be brought back to next meeting</b>  <b>NCPES data to be presented to CNS group for further discussion</b></p> <p>b. Specialist nursing group update</p> <p>JT highlighted that a meeting of the nurses group took place last month, however it was still difficult for some of the specialist nurses to attend due to clinic commitments but it was agreed that the day of the meeting would be rotated. The group indicated that they would like to contribute to the work to develop the Clinical Web Portal due to their role in inputting some of this dataset. In addition JT explained they would like to contribute to the Living with and Beyond Cancer agenda and the Tameside CNS representative intended to submit a bid to the Innovation Fund to undertake health and wellbeing events across the region. MW explained that Macmillan had increased the funding for the Innovation fund from £90,000 to £350,000. JT highlighted that the CNS had asked who the Survivorship Lead was for the Haematological Oncology Board and how the nurses group could engage with them. The next meeting is scheduled for end of January.</p> <p><b>ACTION: SJ to forward contact details of Survivorship Lead</b></p>	<p>MW JT</p> <p>SJ</p>
<p>7. Objective 3 – Research and clinical innovation</p> <p>SW presented the data that had been personalised for Greater Manchester which highlighted the trials available nationally, where these trials were open locally and information regarding inclusion and exclusion criteria can also be found on these pages. This information will be updated every two months. MW asked if the data would be presented as a link or separate sheets and SW felt that a link would be sent out with all the trial map data enclosed. LB remarked that many organisations block the Active X control which would prevent them opening the document.</p> <p>In regards to current Haematological Oncology activity across the region, Simon noted that Greater Manchester were 10<sup>th</sup> overall nationally and 9<sup>th</sup> in relation to interventional trials. MD felt that due to the limited resource, the focus should be on interventional studies. LB asked whether you could identify the cohort of patients who were eligible for a trial. CB explained there was an MDT survey that was conducted to evaluate this and whether trial entry was discussed at an MDT, but the discussion may not have taken place with the patient.</p> <p><b>ACTION:</b>  <b>Contact details for Zoe Coombes to be sent with the minutes to enable Trusts to update their trial activity</b></p>	<p>MW</p>
<p>8. Date of next meeting - 26<sup>th</sup> February 3pm – 5pm 2014 HTU Seminar Room, the Christie</p>	