

Haematological Oncology Pathway Board

Thursday 23rd October 2014, 3pm – 5pm, HTU Seminar Room, the Christie

Attendance	
Name	Pathway Representation
Mike Dennis	Chair
Suzanne Roberts	Bolton Representative (deputy)
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
Usman Ahmad	WWL Representative (deputy)
Montaser Haj	Stockport Representative
Jane Woodward	Patient representative
Rachel Brown	SRR the Christie
Melissa Wright	Pathway Board Manager
Apologies	
Name	
John Hudson	East Cheshire Trust Representative
Steve Goddard	Patient representative
Liz Bates	Patient representative

Agenda Item	Action
<p>1. Welcome and Introductions MD welcomed everyone to the Pathway Board meeting and introductions were made to the new patient representatives.</p>	
<p>2. Apologies Apologies were noted.</p>	
<p>3. Presentation on the Clinical Outcomes Portal</p> <p>MD introduced Jac Livsey (JL) to the Board. MD explained that there were 4 sector MDT's within Haematological oncology and that each had a slightly different way of collecting data and therefore interested in hearing about the work JL has been doing in regards to standardising clinical outcome data.</p> <p>JL explained that the main aim of this project was the standardisation of MDT data across the region and there would be a pilot of the gynaecological pathway and neuroendocrine tumours starting in November. She also identified that the data required on each patient by the DoH from each MDT would be growing over the next year and this will become a commissioned activity. In addition, standardising the data collected over the 4 haematological MDT's would help identify differentiation in treatment decisions and patient outcomes. JL explained that the portal would be web based so accessible from any computer.</p> <p>JL highlighted that the portal would also cut down on the time between decisions by the MDT to the referral for treatment being made and there would be better information to support the referral. JL explained that once adopted, the data in the portal would be managed centrally by Manchester Cancer and would be able to generate reports depending on what is included in the minimum dataset for the pathway. The portal would also be linked with ONS death data. HG asked whether the patients' information could be continually updated to include morbidity and mortality information. JL explained that it was feasible but a more onerous task and this was being collected at clinic on radically treated gynaecological patients at the Christie.</p> <p>JL then presented the Board with a test page of the web portal that had been developed specifically for haematology, and as such would only include data fields relevant for that pathway. The data is divided into pre-treatment or following treatment activities, which supports staging identification with particular reference to patients with a recurrence. JL explained that certain fields will be mandatory such as when patients first experienced symptoms as this is an indicator to delays in diagnosis, performance data and ACE comorbidities which can be amended. JL explained that the minimum dataset will be longer for patients in management following treatment. The data entered creates a work</p>	

<p>list for the MDT Co-ordinator.</p> <p>MD asked if the data could be entered before the MDT. JL explained that this was possible but may not work if the MDT discussions result in significant changes to the data previously entered. MD felt that this would not be an issue for Haematological Oncology MDT's. JL explained that the portal would be integral and support the discussions within the MDT. It would also be future proof as additional indicators could be added more conveniently than the current process through Somerset.</p> <p>HG felt that this system was an improvement. She explained that Pennine did use Somerset but had also created their own online proforma which takes around 2 – 3 minutes to complete. ET asked where the IT support would come from. JL explained that there would be support provided through Manchester Cancer, including support for statistical report and specific data requests. All members of the MDT would be able to access the data, however agreement would be required in order to access other people's outcomes.</p> <p>MD felt that JL had presented an excellent system, however this may need simplifying to use across haematological oncology to get a good mix of required DoH data and data that is clinically meaningful. MD asked how long the pilots will be running for and MW identified that the pilots are due to run for 6 months which would equate to around 1000 patients.</p> <p>Members felt that the portal worked well. There was some concern regarding the amount of data that may be required. RB indicated that this could be reviewed and agreed by the Board. SJ raised concerns about filling in the dataset within the MDT along with chairing the meeting. MH explained that this would be the MDT Co-ordinators role and that the data entry is complete by the time the discussion regarding the patient has ended. SJ explained that their MDT Co-ordinator is not given time to attend the meetings as all MDT data is currently uploaded electronically. UA and SR explained that at Wigan and Bolton, some information is entered by the MDT Co-ordinator within the meeting, however the remainder has to be entered later by the specialist nurse which can be time consuming. MD thought that the Christie MDT could pilot the web portal to identify potential issues and work through any difficulties.</p> <p>ACTION: MD to explore developing a pilot within the Christie.</p>	<p>MD</p>
<p>4. Minutes and matters arising</p> <p>Approval of Chemotherapy Assessors – In regards to the minute related to this, HG clarified that in Pennine the Head of Chemotherapy nursing would be assumed competent to administer chemotherapy and the Consultant Haematologists would be assumed competent to prescribe chemotherapy.</p>	
<p>5. Update from HMDS meeting</p>	

<p>MD explained that the first meeting to discuss the development of this took place on the 4th September. MD felt the meeting was constructive and it was agreed that both CMFT and the Christie would table a proposal for developing a diagnostic service. MW identified that the follow-up meeting will take place on 20th November 3 pm – 5 pm in the Clinical Oncology Seminar Room. MD thought the room was a little small and would check whether the HTU Seminar room could be made available.</p> <p>ACTION: MD to check whether the HTU Seminar room would be available for the meeting.</p>	<p>MD</p>
<p>6. Network research trials resource</p> <p>SW had forwarded a sample Leukaemia research map for comments and explained that he will be meeting with Zoe Coombes in early November to examine the potential of the software. The data will initially include NCRN studies with other studies to follow. MD asked where the data would be hosted and SW thought that it could be held on the Manchester Cancer website and updated every couple of months. MW explained that Manchester Cancer will have a professional area and this could be included as part of site specific information or within the research section. MD felt it was important for Manchester Cancer to invest in the website to ensure it was an effective resource across the region.</p> <p>ACTION: MW to confirm whether research data could be hosted on the Manchester Cancer website.</p>	<p>MW</p>
<p>7. Stem Cell Transplantation</p> <p>ET presented stem cell transplant outcomes from the Christie and CMFT from 2006 - 13. ET explained that the outcome data of both the Christie and CMFT were similar and within the standard deviation although there was a slightly higher relapse risk. Transplant related mortality was also similar across the two Trusts. Overall survival was better for sibling donors than unrelated donors. In regards to transplant related mortality, both the Christie and CMFT had similar rates. JW asked whether the underlying disease has an impact on the survival outcomes. ET explained that it did but this is not reported nationally. Comorbidity data was not included within the analysis but it is hoped that this will be included eventually. MD asked whether it would be useful to present this data in the form of an annual report across the two Trusts. MW asked whether it would be better to include as part of the Pathway Board annual report. MD suggested that the information could be distilled into a couple of slides with a narrative summary. MW suggested that in the first instance the information could go out with the minutes which would be put onto Manchester Cancer website.</p>	
<p>8. Teenagers and Young Adults</p> <p>HG explained that the TYA Pathway Board had its first meeting about 3 weeks ago, where roles and responsibilities were established. The work programme was also being developed and its initial focus was around the notification of TYA patients to the TYA MDT</p>	

<p>from designated sites and the feedback from the primary treatment centre to the referring centre. HG explained that the TYA cancer measures were updated in 2014 and the primary treatment centre is based at the Christie and all regional hospitals can nominate themselves for TYA designated status for different tumour groups. HG identified that most units are TYA designated but these need to be agreed for Haematological Oncology. Most Trusts will have a TYA cancer lead and cancer nurse. Each Trust will have to meet the designated site recommendations and there is a TYA Cancer outreach nurse – Louise Pennington, based at the Christie, who will support Trusts to do this for haematology. HG identified that the notifications required to and from the designated sites for haematology and the primary treatment centre were not working well. MD asked whether the designated sites felt supported by the PTC and HG felt that this was done very well and it may be worth inviting the outreach nurse to the next Pathway Board to explain her role.</p> <p>HG explained that she has developed end of treatment summaries for haematology patients treated at Pennine and follow-up care plans for the teenage and young adults. ET highlighted that these are also used within CMFT. HG thought it would be useful to distribute these to the members of the Board who could then adopt for use within their own Trust. MD thought these could be adopted for use across Manchester Cancer.</p> <p>ACTION: HG to send MW TYA Haematology pathway, treatment summary and care plans</p>	<p>HG</p>
<p>9. Improving surgical access</p> <p>MD explained that to support the understanding of SW had created a proforma to audit information from 2WW referrals. Members felt that this would require a significant amount of time to complete and MD suggested postponing this discussion to the December meeting.</p> <p>There was a discussion regarding the Haematological Oncology Diagnostic Pathway survey. Members felt that this was difficult to complete and much of the information provided would be guess work as the data required is not consistently recorded.</p> <p>ACTION:</p> <p>2WW audit data to be reviewed at December meeting Diagnostic Pathway audit to be put on hold pending results of 2WW audit</p>	<p>Trust Representatives</p>
<p>10. Education event – Manchester Cancer GP Education</p> <p>MW highlighted that following a discussion that took place at the last meeting it was identified that this group would like to hold an education event aimed at GP's. MW explained that several other pathways have expressed a wish to hold similar events so as a team, the Pathway Managers are developing a GP education series. This will attract a large number of GPs as the day will involve a variety of tumour groups. The plan is to cluster the CCG's into three groups and have three separate events with around 130 delegates per event, with Saturday mornings as the provisional session time. Following</p>	

<p>consultation with the GP education lead, the format for the sessions would include each tumour site presenting for 30 minutes on the top 5 tips for query cancer patients with case study presentation. MW explained that volunteers would be required from the Board to present at these events and SW expressed an interest in presenting.</p> <p>ACTION:MW to provide further detail regarding the series once confirmed.</p>	<p>MW</p>
<p>11. Development of clinical guidelines</p> <p>MD has circulated the Lymphoma Lugano guidelines to the group and an AML and MDS meeting will need to be developed by the end of the year.</p>	
<p>12. Specialist Nurses Pathway group</p> <p>JT explained that poor response from CNS' regarding this meeting as they have found it difficult taking time away from their clinical areas. The next date set is Thursday 30th October and to date there have been four responses. ET reflected that the nurses were extremely busy and JT agreed that this was the case. MD asked what the group would be focussing on and JT explained that this was what the initial meeting would be establishing. JT explained that although there is a North West nurses group, these meetings took place quite sporadically. HG suggested setting the meeting at the start of the day and it was agreed that Board leads would encourage their CNS' to attend. MW explained that this issue would also be re-enforced at the Trust cancer leads meeting.</p> <p>ACTION: JT to arrange future meeting date in the morning</p>	<p>JT</p>
<p>13. Living with and beyond cancer – Innovation fund and Education Event</p> <p>MW explained that there would be an education event on 25th November to explain the living with and beyond cancer initiative in more detail and provide information regarding applying for the innovation fund. MW explained that there are national standards linked to this which highlight the benefits of new models of follow-up and the provision of specific information to patients and primary care including holistic needs assessments and treatment summaries. MW highlighted that there has been some work undertaken to survey what is available within the region and it had been noted that there seemed to be a lot of variability across some Trusts. The innovation fund will be used to support pathways in standardising this care and highlighting the living with and beyond agenda. The closing date for all applications 31st December 2014.</p>	
<p>14. Patient Communication</p> <p>MW identified that this item had been raised at the last meeting, following a discussion between JW and CB on how quickly treatment decisions are fed back to patients following an MDT. A survey was going to be sent out to get an understanding of what happens across the region. SR explained that this had not been completed yet. JW explained that it can be difficult for a patient to know that these discussions were taking place and not know when decisions would be communicated. ET explained that the patient and the</p>	

<p>doctor would usually discuss what treatment options would be discussed prior to the meeting. SJ explained that the National Cancer Patient Experience Survey asked patients about these discussions and HG indicated that the region performed poorly on this question.</p> <p>ACTION: CB to send out survey to Trust representatives.</p>	<p>CB</p>
<p>15. A.O.B.</p> <p>Allied Health Professional representation on Board – MD explained that there was a Manchester Cancer Board for Allied Health Professionals (AHP) and they had expressed some concern regarding a lack of AHP representation on this Board and had nominated someone to attend this Board if this was acceptable. Members did not express any objections to the nomination.</p> <p>MW explained that the National Cancer Patient Experience Survey for 2013 would be available shortly and would be sent out to Board members.</p> <p>SW identified that the Academic Foundation Programme interview shortlisting process will be taking place and asked members for their support with this.</p> <p>ACTION: MD to make final decision on AHP nomination.</p>	<p>MD</p>
<p>16. Date of next meeting - 18th December 3pm – 5pm 2014 HTU Seminar Room, the Christie</p>	