

Haematological Oncology Pathway Board

Thursday 26th February 2015, 3pm – 5pm, HTU Seminar Room, the Christie

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

Agenda Item	Action
<p>1. Welcome and Introductions</p> <p>MD welcomed everyone to the Pathway Board meeting and introductions were made. CB identified that SJ would continue to be the lead representative for Salford and she would deputise.</p>	
<p>2. Apologies</p> <p>Apologies were noted.</p>	
<p>3. Minutes of the last meeting</p> <p>Item 14: Patient Communication</p> <p>ACTION: Clare Barnes will be sending out a questionnaire to all Trusts. Patient Communication to be an agenda item at the next Board</p> <p>Item 6 (b) MW indicated that she had made contact with the Survivorship Lead and will be meeting with her on 10h March.</p>	<p>CB MW</p>
<p>4. Manchester Cancer Objective 1</p> <p>(a) Improving Outcomes/survival rates</p> <p>HG explained that she has now collated the data on all 57 cases, but the analysis was not complete. HG indicated that around 50% of patients would be classed as an inappropriate referral, however further analysis would need to be undertaken to discover what the GP suspected diagnosis was and what the actual diagnosis was. HG has also identified that Pennine are over investigating their younger patient groups who had reactive nodes and identified that there are no protocol guidelines in relation this issue.</p> <p>HG indicated that the data only related to patients entering the pathway through haematology and the delays relating to biopsies generally took place when patients are initially referred through another speciality. HG agreed to attach the Pennine 2WW proforma to the final analysis and MD thought it would be useful if the proforma was standardised across the region. JT asked about patients who aren't referred on the 2WW pathway but are diagnosed with cancer. HP identified that a lot of these patients enter via the ENT pathway and indicated that surgeons can upgrade patients where necessary. SW felt that patients within 'grey areas' such as CLL are seen less quickly and are disadvantaged because of the 2WW system. HG felt that there were a lot of these types of cases within the data but she could understand the rationale for the GP referring through the 2WW pathway.</p> <p>ACTION: Further presentation of the Pennine data All Trust representatives to distribute their 2WW proformas</p> <p>(b) MDT process and outcomes</p> <p>MD explained that there is a southern sector MDT pilot for the clinical web portal and highlighted that there have been delays due to information governance issues. The system will be ready to refer patients from March. MW explained that the regional pilot taking place within gynaecology had been completed and the evaluation will be presented to Manchester Cancer Provider Board.</p>	<p>HG Trust Reps</p>

<p>(c) NICE suspected cancer guideline</p> <p>The NICE guidance in relation to suspected haematological oncology were reviewed. MD highlighted that although the new guidance was fairly explicit, he felt that the symptoms indicated were vague. SW felt that all the symptoms within the new guidance were already on the 2WW proforma and it identified preliminary diagnostic tests to be undertaken within primary care before referring. MW explained that the consultation for the guidance was closed and the guidance was due to be published in May. MD thought that this would be an opportune time to plan an education event for primary care. MW explained that Manchester Cancer is planning a module style GP education event that haematology could input into. MD also explained that NICE are looking to update the 2003 Improving Outcome Guidance but are still within the planning stage.</p> <p>ACTION: MW to update on the progress with GP education event</p>	<p>MW</p>
<p>5. Objective number 2 – Improving the patient experience</p> <p>(a) National Cancer Patient Experience Survey 2014</p> <p>MD asked each Trust representative to reflect on their performance within this survey and identify any action taken by their Trust. MH explained that Stockport had discussed their performance locally with their cancer lead, quality lead and haematology representatives. MH feels there is a need to increase the awareness of patients of the support provided within the department. SR explained that Bolton has insured that information on research is available within clinical areas. She highlighted that research was poorly provided at the Trust and she has had difficulty getting support from the research team and pharmacy to open new trials. There was also only one research nurse supporting all pathways. ET indicated that MRI performed poorly in regards to providing care from social services and indicated that there was no social worker available, but this post would be recruited to. ET would also like the ambition of the Trust to be to score a lot higher than national averages. CB referenced that question regarding patients told sensitively about their diagnosis and wasn't sure if this was due to the busy environment of the day unit.</p> <p>JT explained that this was discussed at the CNS' group and specifically the question regarding contacting their CNS. She will be working with Manchester Cancer to look more closely at how this question was interpreted by patients. HB indicated that Tameside has discussed their performance within their department and there will be work undertaken on providing information and adequate staffing. HG indicated that Pennine have lots of patients engaging in the survey. HG has undertaken work on this and 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 in their survey results. This has been highlighted as a serious concern within Peer Review and a business case was written to expand the CNS provision which was approved but there was no funding to action. HG explained that funding through Macmillan may not meet the needs of the service as Macmillan have very specific requirements of nurse posts they fund. HG reflected on the discrepancy between the CNS support at Pennine as opposed to other Trusts with a similar population and feels that addressing this is key to improving their performance at NCPES. HP explained that WWL will be looking at survey in detail next week and have an action plan that is being developed by their CNS' and cancer lead.</p>	

<p>ACTION: Trust representatives to provide information on commercial and non-commercial trials open and research nurses employed by Trust and the Clinical Research Network</p> <p>National research capacity data to be provided to benchmark performance Overview of the inequity of CNS support in Pennine to be provided MD to write to Pennine Lead Clinician regarding their CNS capacity</p> <p>(b) Specialist Nurses group update</p> <p>JT identified that there was still difficulty of getting nurses to attend. JT explained that she will try to expand the number of contacts from each Trust on the invite list. HP also suggested giving six weeks' notice in order that clinics can be rearranged. MD suggested that including an education element may encourage more nurses to attend.</p> <p>ACTION: Trust representatives to encourage their CNS's to attend the next meeting</p>	<p>Trust Reps</p> <p>MD HG MD</p> <p>Trust Reps</p>
<p>6. Objective 3 – Research and clinical innovation</p> <p>(a) Network resource trials resource update</p> <p>SW explained that he met with the new Clinical Network Research Manager regarding the trial maps. Further work will need to be undertaken to look at how the research data can be linked to the Manchester Cancer website on a regular basis.</p> <p>HP identified that at present, chemotherapy for haematology at WWL has been an issue particularly in regards to running trials. There is no designated dispensing pharmacy as this has now been taken over by the Baxters. It was anticipated by the WWL Consultants that the Christie would be delivering the service for haematology but this has not happened. HP asked whether the Christie could take on this role at WWL for haematology</p> <p>ET asked about the commissioning support for payment of excess treatment costs as this was impacting on the ability to open trials in Pennine, Salford and CMFT.</p> <p>ACTION: MD to raise the chemotherapy issue with the Lead Research Pharmacist at the Christie MD to investigate the payment of excess treatment costs regarding AML 18, AML 19</p>	<p>MD MD</p>
<p>7. Objective 5 – Improving and standardising high quality care across the whole service</p> <p>(a) Update from HMDS meeting</p> <p>MD indicated that progress was being made on developing the diagnostic service which was in part due to the pivotal work undertaken by the Pathway Board and felt encouraged that Leeds were being so accommodating in regards to the configuration of the new service. This issue was brought to the attention of the Manchester Cancer Provider Board and MD explained that there was a meeting earlier in the week attended by clinical and management representatives from the Christie</p>	

<p>and CMFT along with clinical representatives from Leeds and the Medical Director of Manchester Cancer. There continues to be broad support for the proposal agreed by the Pathway Board and following the meeting a statement was prepared for the Board to update on what was achieved:</p> <p>‘There is an unchallenged, clear and urgent need for a conurbation-wide, collaborative and compliant HMDS service. GM does not have the current infrastructure to provide this and needs to work with a partner such as Leeds HMDS. In addition, the current fragmented service needs to be coordinated with an emphasis on standardisation of (double) reporting and local MDT diagnostic support to ensure robust clinical discussion.</p> <p>The Manchester Cancer Haematological Oncology Pathway Board have agreed in December 2014 to support the further development of the HMDS service by working collaboratively with Leeds through a CMFT hub in order to achieve these objectives. In addition, Leeds have indicated their preference to work more closely and in a coordinated fashion with GM through the CMFT hub rather than the current ad-hoc arrangements that many GM units have already set up with Leeds.</p> <p>Further productive discussions with Leeds HMDS, and between the Christie and CMFT in February 2015 have built on this momentum, with an outline agreement in strategy, emphasising collaboration and use of current GM resource where appropriate.</p> <p>We can announce that a working oversight group is being set up, with a chair and deputy chair to be appointed, which will work inclusively and collaboratively with all partners to realise this joint vision for an appropriately badged, conurbation wide solution between GM and Leeds. It is anticipated there will be various work streams to clarify the details including all clinical and operational/ financial issues. A real emphasis will be placed on both quality and value. Terms of reference and an effective timeline are currently being described and discussions between Leeds and all GM stakeholders will now proceed at pace.’</p> <p>MD asked about the chairing of the working group and it was agreed that John Burthem would be an appropriate candidate with Adrian Bloor acting as deputy chair.</p>	
<p>ACTION: The communication to be forwarded to the Pathway Board Trust representatives to forward this information to their department and seek expressions of interests for the working group</p> <p>(b) Clinical guidelines</p>	<p>MW Trust Reps</p>
<p>MD explained that there was a meeting with the AMLgroup and the guidelines should be ready by the middle of March and indicated the MDS group would be meeting on the 6th March. MD identified that CLL and Lymphoma should be updated as they are over two years old.</p> <p>ACTION: MD to write to the authors of the guidelines regarding their update</p> <p>(c) Stem cell transplant</p> <p>ET explained that ‘Manchester Transplant’ is still keen to put a bid in to host the EBMT 2019</p>	<p>MD</p>

<p>conference but feels it may be too early to consider this as it was held in London three years ago. The process involves writing a letter expressing interest in hosting the conference, following this, three regions would be selected and a full bid would be required. Members thought it would good to express an interest in the first instance.</p> <p>ACTION: ET to express interest for Manchester hosting the 2019 conference</p> <p>(d) Teenagers and Young Adults</p> <p>MD explained that LP had attended the meeting to discuss how TYA patients can be supported across the region. LP indicated that her post was funded by the Teenage Cancer Trust, and although she is based at the Christie, she provides an outreach service to the designated Trusts working with TYA patients alongside their CNS. LP would like Trust representatives to refer into the service for patients between the age of 16 up to their 25th birthday. Once the referral has been made, LP can identify whether the patient has a specific TYA need. LP explained that the aim of the service is to help this age group to get back to their normal lives as quickly as possible and would like the referral to be a standard part of their treatment.</p> <p>ACTION: LP contact details to be circulated with the minutes TYA referral to be raised in Trust Cancer Board meetings LP to feedback to the Board if there are any further issues to raise</p>	<p>ET</p> <p>MW Trust reps LP</p>
<p>8. A.O.B</p> <p>MD asked BC if there were any issues that she would like to bring to the Board. BC indicated that she would be able to feedback the outcomes of the AHP meeting to the next Board meeting.</p> <p>MW highlighted that this Board was yet to nominate an Early Diagnosis Lead. MW explained that this role would essentially ensure that information from the Early Diagnosis Strategy group was fed back to the Board and would not require the attendance of additional meetings. MH agreed to take on this role.</p> <p>MD explained that Peer Review had notified the network that there will be inspections and visits for Haematological Oncology in the latter part of the year. MD thought it may be worthwhile for Trusts to bring along their capacity audits to evaluate at the June meeting. HG explained that this requirement that this had been moved from haematology to chemotherapy measures.</p> <p>ACTION: Capacity Audit to be discussed at June meeting</p>	<p>MW</p>
<p>9. Date of next meeting - 23rd April 3pm – 5pm 2015 HTU Seminar Room, the Christie</p>	