Haematological Oncology Pathway Board

Thursday 28th August 2014, 3pm – 5pm, HTU Seminar Room, the Christie

Attendance	
Name	**Pathway Representation**
Mike Dennis	Chair
Clare Barnes	Bolton Representative
Jo Tomlins	Nursing and Christie Representative
Fiona Dignan	CMFT Representative (deputy)
Hayley Greenfield	Pennine Representative
Hussein Baden	Tameside Trust Representative
Simon Jowitt	Salford Representative
Simon Watt	UHSM Representative
Chris Gregory	WWL Representative (deputy)
Jane Woodward	Patient representative
Liz Bates	Patient representative
Melissa Wright	Pathway Board Manager
Apologies	
Name	
John Hudson	East Cheshire Trust Representative
Steve Goddard	Patient representative

Agenda Item	Action
1. Welcome and Introductions MD welcomed everyone to the Pathway Board meeting and introductions were made to the new patient representatives.	
2. Apologies Apologies were noted.	
3. Minutes and Matters Arising <u>Item 4</u> JT explained that the Specialist Nurses would be meeting on the 9th October. It was agreed that Specialist nursing, TYA and stem cell transplants would become standing agenda items. <u>Item 5</u> MD reported that Jac Livsey had agreed to attend the Pathway Board meeting in October and is working with a Haematological trainee (Rachel Brown) to develop haematology specific proformas. MD explained that there was a meeting next week to discuss the development of a local haematological oncology diagnostic service. SJ explained that haematology training may be changing, but it is not yet confirmed what the new model of training would look like. <u>Item 11</u> MD has met with Dr Baden and is in contact with the Medical Director at Tameside and will be visiting the Trust shortly. **ACTION: MW to amend item 5 on previous agenda.**	**MW**
4. Haematological Pathway Board annual report and annual plan MW explained that each pathway area had been asked to produce an interim annual report and a plan of their vision for their pathway as well as develop a plan for the next year. These were presented to the Provider Board two weeks ago and although there hadn't been any specific enquiries from the Provider Board in regards to Haematological Oncology, it is anticipated that each Pathway Director will be asked to present their plans and progress against it in the coming year.	
5. Development of a regional Specialist Integrated Haematological Diagnostic Service MD explained that this would be a big priority in the work programme of Haematological cancers and a meeting had been set up for next week to discuss the setting up of a local resource to provide a better service than currently provided in Leeds. Pathologists from all Trusts have been encouraged to attend. SJ felt that the service could reduce costs, however MD	

explained that the Leeds service is seen as quite competitive and there would be costs in infrastructure including laboratory costs for a local service. MD thought it would be important to assess whether all Trusts would have confidence in using a local diagnostic service. MD explained that a generally held view is to develop a service, which in time, would become self-funding. The focus for next weeks' meeting would be to set out the rationale and the vision for this service for Manchester and this would involve highlighting the service would be supporting a city with a large population. SW asked whether MD has spoken to anyone in Liverpool regarding the challenges of setting up a local service. MD explained that he had, and reflected that it would be important for all organisations within Manchester to feel confident and commit to using any locally developed service. It would be important for there to be a balance between diagnostics conducted 'in house' and those sent out to the specialist regional service. LB said that there was evidence that with people living longer and experiencing second and third cancers, some of which were brought on by the side effects of chemotherapy, there would be more haematological cancer incidence in the population and this may require a larger number of laboratory services. SW acknowledged that it would require work in getting agreement from all necessary stakeholders as this had not been the case in the previous local service. JW asked what the impact would be for patients. MD explained this would be variable depending on the specific diagnosis and treatment, the problems are generally with the less acute malignancies where specialist testing and second opinions are required.	
6. Evaluating Clinical Outcomes It was agreed that the challenge in the collection of data at MDT level was that each organisation is collecting different data on different systems and this makes comparability difficult. Jac Livsey will be attending the next Pathway Board meeting to present the Clinical Outcomes database. Trust representatives were encouraged to bring along a member of their team responsible for data entry. This has been presented to Manchester Trust Chief Executives via the Provider Board and Jac has also presented to other Pathway Boards who have been very positive regarding the functionality of the database. The Provider Board have agreed to pilot the dataset for gynaecological cancers with a further pilot roll out to be agreed following its outcomes. SW explained that he had been speaking to Celgene, who are a drug company and they would be quite interested in supporting the development of local databases. LB asked whether the NCIN had been involved as they are funded through a variety of sources, including CRUK and Macmillan and they may be able to support this project via the NCIN.	
7. Network Research Trials SW explained that he had met with Zoe Williams – Clinical Network Research Manager at the beginning of August and SW suggested providing reports every 6 months. He identified that the National Clinical Research Network 'maps' are available at a national level electronically and identify what trials are available, with the inclusion and exclusion criteria. Zoe suggested that	

Manchester Cancer could adapt the maps to provide local information and will be looking into this. The maps could then be updated every two months across the network. SW explained that individual Trusts would still need to provide information on their non-CRN trials. MD asked about developing a newsletter. HG felt that the map tool would be sufficient information with new and opening trials on the front cover SJ suggested presenting this information to the North West Haematology group. HG suggested CMFT and the Christie nominating someone in the research trials department to provide support with updating the trial data. SW also feedback that Zoe suggested developing a study within Greater Manchester. MD explained that Haematological Oncology had been identified as a focus for the Manchester Research Centre and this could be explored once this centre was up and running. LB asked if there were patients eligible for trials who are currently not on a trial. CB explained that this was looked at within the old network group, but this process could be reviewed. SW also thought the challenge for some patients to travel to trials might need to be addressed. MD explained that there are resources to support many trials. JW explained that some patients may not be receptive to taking on a trial as this is suggested soon after they are diagnosed. JW asked whether patients could access trial data. SW explained that the NCRN maps are available on their website. **ACTION: SW to work with Zoe Williams and Manchester Cancer to establish directed open access to trial information**	**SW**
8. Improving Surgical Access To support the understanding to the barriers to accessing surgical intervention. MD will be circulating a questionnaire to all Trust representatives and explained that the new guidelines are still being agreed. MD suggested bringing this agenda item back to the next meeting. **ACTION:** **MD to circulate questionnaire regarding access to lump/node biopsy diagnosis** **MD to circulate updated guidelines (Lugano)**	 **MD** **MD**
9. Review of HSC205 data These were reviewed by Trust for the last financial year. <u>Pennine</u> HG explained that from April – November 2013 there had been one breach, however from November 2013 there had been 12-13 breaches. All but one breach had come originally from another tumour site and all the breaches were lymphoma patients and there had been long delays in histology, head and neck, fine needle aspirations and some patients did not attend their appointment. SW asked whether these would be classed as a breach. LB explained that some patients would not have been informed by their GP that they were being referred for a suspected cancer. HG felt that the increase in breaches may be due to a high number of complex patients. <u>CMFT</u> FD explained there had been 4 breaches and they were all lymphoma patients. All patients	

started in a different tumour groups and were then referred on. The delays were due to complex diagnostic pathways and patients requiring multiple tests.

Wigan
CG identified for haematology 2WW there were no breaches, however overall they had had 3 breaches, all originating from head and neck which were then referred on.

Salford
SJ explained the results from Salford were similar to the experiences of other Trusts and it was rarely a haematological issue. SJ also explained that clinicians were not invited to the route cause analysis meetings where breaches are discussed. HG explained that she routinely asks for the data from the meeting. SJ thought the only way that solutions for breaches could be found is through clinicians discussing the issues impacting on the pathway with each other.

Bolton
CB identified that there were no breaches in Bolton last year, however she thought it was important to think about how patients requiring surgical access could be supported through the pathway and how to develop working relationships with the referring cancer pathways. CG explained that their CNS have a good liaison with other tumour sites and do attend ENT clinics.
Tameside
HB reported that there were no breaches for the last year.

JW explained that there was difficulty to get a referral at a GP level but once referred things moved fairly smoothly. LB thought it was important to educate GP's about when it would be appropriate to refer to a haematological oncology service and also to ensure patients who are on the wrong pathway can be referred to the right one. SJ said that could be done fairly easily. LB asked whether clinicians would see a 2WW referral prior to the patient coming into clinic. It was felt within the meeting that some doctors would see some of the referrals but perhaps would not see them all. Some Trusts have electronic systems that book patients into the next available slot in order to comply with their cancer wait targets.

LB felt that if doctors were unable to see the referral prior to a patient going to clinic, there would not be an opportunity to contact the GP which could in turn support their educational needs. SJ explained that Salford's referral form clearly recommends that the GP should discuss with a member of the haematological team prior to the referral, however this rarely happens.

MD asked if members held GP education events. SW indicated that the GP's attending were generally not those making the inappropriate referrals. LB felt it would be better to go to GP protected learning events. CB indicated that she has attended one of these events and GP's wanted education on other areas of haematology as cancer was not considered a high priority. CG thought it would be important to screen all the referrals prior to clinic.

SW asked if Trusts should audit their 2WW referrals to identify any patterns and determine the diagnosis for non-haematological cancers. MD thought that trainees could support this piece of work. SJ though that this would need a universal proforma for all Trusts to input their data

ACTION: **MW**

MW to identify when GP protected learning takes place **SW to design a proforma for the 2WW referral audit** **All Trusts to audit Q1 2013-14 data for 2WW referrals**	**SW/Trust Reps**
10. Review of SACT data MD felt that this data highlighted the coding issues and thought that more information regarding treatment and toxicity rates would need to come via other routes. JT asked whether SACT 30 day mortality rates would be better at identifying treatment issues. MD explained that he had meet with Prof Gordon Jayson, the Pathway Director for Systemic Therapy. MD explained that his group would like to synergise the governance structure with a preferable single governance structure. He would like to meet with the group to develop his understanding regarding haematological oncology and explore this further and will be attending the Pathway Board in December. **ACTION: JT to investigate with CNS whether 30 day SACT mortality data and the SACT processes.**	**JT**
11. Approval of Chemotherapy Assessors (Chemotherapy standard 14-3S-110) MD explained that ET had asked to raise this on the agenda. She had indicated that she thought the Pathway Board would have a role in authorising the chemotherapy assessors, however MD felt that this was up to individual organisations to undertake and the Pathway Board would have no involvement in this process. HG identified that in her Trust the Head of chemotherapy nursing would be assumed competent to prescribe chemotherapy and to authorise someone as an assessor and that this was a Peer Review requirement. HB explained that in his Trust a chemotherapy nurse who hadn't handled a particular regimen within a year had to be externally assessed. MD highlighted that the Christie have a policy for trainees, where supervisors would go through protocols. HG explained that their trainees are given the educational resources and have to sign to indicate that they have read and understood, this will then be included in the Peer Review portfolio.	
12. Development of clinical guidelines MD explained that he had been in contact with relevant people to support the development of the outdated guidelines. **ACTION: MD to update at next meeting**	**MD**
13. Educational Event MD remarked that although the Board had previously discussed having an event focussed on rare haematological diseases, on reflection it might be useful to focus on patients or nursing. JT explained that she would take this proposal to the specialist nursing group however there was a North West nurses group that provide educational sessions on a regular basis. JW explained that some of the haematological cancer groups have their own patient events. LB explained it might be useful to have an event focused on survivorship issues, which may have a	

more generic feel but would support patients in managing their condition. FD explained that her Trust had discussed putting on a Manchester based survivorship day similar to the Anthony Nolan Trust day organised in Leeds. MD thought it might be useful to have a joint North West medical and nursing session. **ACTION:** **JT to develop specialist nursing event in collaboration with NW Haems (nursing)** **MW- as item 9 to evaluate GP educational session**	**JT** **MW**
14. A.O.B Idiopathic thrombocytopenic purpura study – MD explained that Lisa Cooper, who works at Stepping Hill, is undertaking a national survey on this area and will be contacting Trust representatives to take part in this. CB asked whether there was a process for MDT's feeding back treatment information to patients. CB thought it would be useful to survey Trusts to identify whether this may need to be standardised. HG identified that Peer Review indicates a timeline for informing patients. SW explained that he would time the next clinic appointment for patients for after the MDT. SJ explained that CNS would phone the patients after the meeting. HG felt that a phone conversation to the patient would not always be appropriate and would tend not to do this. SW would explain to patients before the MDT that he would be ringing them with and A or B scenario. LB asked whether patients could take an active role within the MDT. SJ thought that this would be difficult due to confidentiality of other patients and MD thought that the key worker for each patient represented this role very well. **ACTION: CB to send out survey to Trust representatives**	**CB**
15. Date of next meeting - 23rd October 3pm – 5pm 2014 HTU Seminar Room, the Christie	