GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Oesophago-gastric Pathway Board

OG Clinical Pathway Board

Minutes of the meeting held on

31st March 2017

Members in attendance

Mr J Vickers	Salford (Chair)	Colin Jackson	Patient Representative
Mr David Ardern	Patient Representative	Dr B Rameh	PAT
Mr B Smajer	Bolton	Dr R Hubner	Christie
Dr K Koss	East Cheshire	Dr Was Mansoor	Christie
Dr R Willert	CMFT	Louise Porritt	Stockport
Dr A Law	Bolton	Mr A Li	CMFT
Dr L Bhatt	Christie	Dr R George	PAT
Michelle Eden- Yates	SRFT	Julie Fletcher	WWL

In attendance

James Leighton	GM Cancer	Sarah Darley	Respect 21
Michelle Leach	Macmillan UIT		

Members sending apologies and no deputy

Sue Liong	UHSM	Mr B Abduljalil	Tameside
Ann Anderton	WWL	Mr S Galloway	UHSM
Dr S Hayes	Salford	Dr R Keld	WWL

1. Welcome and introductions

JV welcomed all to the meeting and noted the apologies received.

2. Minutes of the last meeting.

These were accepted as an accurate record of the meeting.

- Matters arising not on the agenda

JV asked about the audit into non-oncology surgical patients and JL confirmed that this was still to be undertaken.

There were no other matters arising.

3. GM Cancer plan

Discussion summary	JL advised the meeting on the content and status of the GM Cancer plan. The board reviewed the tabled document which outlined the immediate objectives that have been set. The board discussed the need for follow-up protocols and RW informed the board that NICE will be publishing guidance on this and advised that the board should await this. He agreed to present this to the board once it is published. The board then reviewed adoption of the recovery package and JV asked the CNS group to review what is currently provided. When discussing the education plan WM confirmed that there was a study day arranged at the School of Oncology in October. The board agreed to support this. JV also agreed to discuss this with the Colo-rectal and HPB boards to assess the scope for collaboration. BS informed the board on the "Find out Faster "project currently running in Bolton. He confirmed that it was a CCG led project and that data on the impact was not yet available. JL offered to contact the CCG and see what was available.
Conclusion	The board agreed to deliver the set objectives and any others that will be set in the future
Actions & responsibility	**JL to table NICE guidance on OG follow-up at future meeting** **ME and LP to review the current recovery package provision** **WM to provide details of Christie OG study day** **JV to discuss joint event with the Colo-rectal and HPB boards** **JL to review the Bolton "Find out faster" project** **JL to table a report at the future meetings of the board**

3.1 Service guidelines

Discussion summary	JL confirmed that there had been no drafts received as yet. JV again asked that the board members complete their sections.
Conclusion	The board agreed to complete the guidelines for the October deadline.
Actions & responsibility	**The following members were nominated to complete the relevant sections.** **RH & LB Oncology** **SG Junctional** **BA and AL Gastric & Oesophagus** **RH agreed to co-ordinate the palliative care guidelines**

3.2 Barrett's service model

Discussion summary	This item followed on from the endoscopy guidelines that were discussed at the last meeting of the board. In a subsequent email exchange RK proposed that in order to improve the diagnosis of Barrett's adenocarcinoma he argued that the only way to do this is through a Barrett's surveillance programme. He proposed a model of a maximum of x2 endoscopists per trust performing Barrett's Surveillance. They would follow BSG/NICE guidelines and each endoscopist would be specifically trained for this role. BS explained that within Bolton there was a lot of support for this model and had identified two endoscopists to take on the role. RW also supported the principle but advised that it was not within the remit of this board to manage the training programme and could be delivered locally by Trusts.
Conclusion	The board were in support of this proposal but felt it should be managed and delivered within Trusts. It was agreed that it was not appropriate for the board to provide a training function for this.
Actions & responsibility	**There were no actions for the board form this report.**

3.3 SMDT – transformation

Discussion summary	JV explained that the Board would be providing advice to the implementation Board on restructuring the MDT process and invited the Board to express their views. He discussed the tabled document and reviewed all three models proposed. The board agreed that there was no intention to work for an all-day MDT as this was not in the best interest of the patients. The board also agreed that model three, the stratified model, was not one that could be supported. There followed a wide ranging discussion on the appropriate attendance, the efficient use of resources and the model of delivery of MDT provision. The board agreed that any changes should ensure – • Minimum effect on job plans • That all patient reviews are of the highest standard • That the patient advocacy function is maintained by the local Trust • That the identified core membership is present in the meeting room JV thanked all for their input and assured the Board that the implementation Board will be made aware of their views.
Conclusion	The board noted this discussion.
Actions & responsibility	**There were no actions for the board form this discussion but agreed to keep this under review at future meetings.**

3.4 Vanguard Best practice timed Pathway project

Discussion summary	JV confirmed that initial discussions had taken place on this but there had been no progress subsequently.
Conclusion	The board noted the content of this report.
Actions & responsibility	**There were no actions for the board form this report.**

4. Service transformation and the single service

Discussion summary	JV provided an update from the implementation board. He confirmed that work had now begun implementing the decision of the Transformation board. They first meeting of the group was held in March and had representation from each surgical centre and had an independent chair. Initial discussion was on moving patient cohorts, emergency cover and rota, SMDT and specialist endoscopy services. He explained that the deadline was not set and did not anticipate it happening via a “big bang” approach.
Conclusion	The board noted the content of this report.
Actions & responsibility	**There were no actions for the board form this report.**

5. Research and education update

5.1 RESPECT 21 Sampling site

Discussion summary	SD explained that the team have been looking at sampling hospital sites for the qualitative arm of the study (the protocol states one specialist centre, one specialist centre that becomes a local centre and one local centre that remains a local centre should be included in the sample). As there is only one specialist centre (SRFT) this would obviously be included. She then explained that as there are two 'specialist centres' becoming 'local centres' (CMFT/UHSM), but given that there are only two of them and they are coming together anyway it would seem feasible and sensible to include them both. That means there is a need to select a local centre which is staying a local centre out of the other hospital sites. She explained that in London the factors that were taken into consideration were changes to referral pathways and travel times/distance. It seems that many of the local centres referred to SRFT anyway, and that the team propose that the centre to include in this category is Stockport NHS FT.
Conclusion	The board agreed that Stockport should be the local sampling site
Actions & responsibility	**SD to feed back the view of the Board to the RESPECT 21 team.**

6. National OG Cancer audit

Discussion summary	JL spoke to the tabled document and explained that it was report drawn from the Vanguard data team and was for information only. He also confirmed that there was some more data published on incidence and mortality and he agreed to circulate to members. All are attached below. Adobe Acrobat Document Adobe Acrobat Document Adobe Acrobat Document
Conclusion	The board noted the reports
Actions & responsibility	**JL to circulate the incidence and mortality reports with the minutes**

7. Any other business

7.1

Discussion summary	BS asked the board if there were any intentions for the Board to review pathway breaches. JL confirmed that this was now considered to be normal business for the Board as part of the cancer plan.
Conclusion	The board noted this discussion.
Actions & responsibility	**JL to add pathway breaches to future meeting agendas.**

7.2

Discussion summary	RG advised the board that the European Society of Gastroenterology guidelines on ESD were now published and asked that the Board consider adopting them. JV confirmed that he was happy to acknowledge the guidelines but responsibility for adoption would be for local providers.
Conclusion	The board noted this discussion.
Actions & responsibility	**There were no actions for the board.**

8. Date and time of next meeting –

Friday 26th May 14.00 – 16.00hrs

Meeting room TBC, Mayo Building, SRFT

Meeting dates 2017

Friday 28th July	**14.00 – 16.00hrs**
Friday 29th September	**14.00 – 16.00hrs**
Friday 24th November	**14.00 – 16.00hrs**