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

26 September 2018 - 10:00 - 12:00

The Northern Tennis Club, Didsbury

Members in attendance

Mr J Vickers	Salford (Chair)	**Was Mansoor**	Christie
Christie Peel	WWL	**Elaine Hayes**	Patient Representative
Amanda Law	Bolton	**Tina Foley**	UHSM
Hamid Sheikh	Christie	**Marc Abraham (Mab)**	Christie
Bohdan Smajar	Bolton	**Dr R Willert**	MUFT
Zola McFarlane	PAHT	**Sue Liong**	UHSM

In attendance

James Leighton	GMC	**Catherine Perry**	Respect 21
Fiona Lewis	GMC	**Vikki Owen Holt**	Christie
James Turner	Christie LWBC	**Anne Raftery**	GMC Palliative care
Mel Atack (MAt)	User Involvement		

Members sending apologies and no deputy

Dr K Koss	East Cheshire	**Stephen Hayes**	SRFT
R A Li	CMFT	**Mr S Galloway**	UHSM
Ann Anderton	WWL	**Mr B Abduljalil**	Tameside
Michelle Eden- Yates	SRFT	**Louise Porritt**	Stockport
Mr B Alkhaffaf	CMFT	**Colin Jackson**	Patient Representative
Dr R Keld	WWL	**Julie Fletcher**	GM Cancer Director Ops group
Ms R Melhado	SRFT		

1. Welcome and introductions

In the immediate absence of JV, FL welcomed all to the meeting and invited attendees to introduce themselves.

2. Minutes of the last meeting.

These were accepted as an accurate record of the meeting.

Palliative care provision - MA explained the personal impact statement which the patient inputs any personal information they wish their clinical team to consider, this needs to be filled in and go to the MDT to take into consideration. It is understood that this is a pilot trialled at Gynae MDT at Christie.
ACTION: FL to circulate the patient impact form used by Gynae MDT to members of this board.
A discussion followed around communication between providers

Discussion summary	EH felt that information given to patients is inconsistent especially where care is between different provider trusts and wondered whether any progress had been made on this. EH was asked if she was aware of any feedback on the surgical pathway +/- clinical oncology pathway, as patients do tend to see different clinicians along the pathway for diagnosis and treatment which can change along the way. The preference to see the same clinician vs seeing a number of clinicians was discussed as this will impact on the speed of which patients can be seen. Following some discussion, it was felt that there is a piece of work around communication and preference of who the patients prefer to see, and that the patient user group could feedback on.
Conclusion	JV agreed it is a complex pathway where patients are being seen in different providers. Justifiable questions being asked from patients of clinicians at all levels. We have a responsibility to provide consistency and continuity when passing patients from one to another particular in a complex pathway, that the key worker and communication of transfer of care between providers is good. We do have an opportunity now that we have reconfigured the service to reduce the variation using patient.
Actions & responsibility	**MAt will explore how to take this back to the support group and will update this group.**

3. Review of membership

Discussion summary	JV explained that the current membership is now 4 years old with the original ask that all trusts and all clinical groups are represented. It is in the ToR that all trusts are given the opportunity to be represented unless they chose not to. The group were in agreement that the required minimum commitment is for members to attend at least 4 out of 6 meetings as long as meeting dates are sent out 12 months in advance. Each member to send one named deputy to be sent to FL for continuity. Following some discussions around recent changes on the pathway and options on how different boards are run, it was concluded that JV and FL will explore these. All diagnostic groups will continue to be represented with their role to feed back to their GM counterparts/Trusts. JV also felt that the preference for people to be an MDT member to be on this board however Sue Liong agreed to be the link outside this forum to other relevant interventionist colleagues.

	Sue Sykes will be the commissioning rep for this group GP rep to be confirmed. Suggestions welcomed if members are aware of anyone in GM.
Conclusion	The members provided guidance on the future representation and membership
Actions & responsibility	**JV/FL to explore how other boards are run.** **JV will contact members who have not attended for their intentions.** **Committed members will continue to be represented** **TF will liaise with AM re: Patient representatives** **Members to send a named deputy to FL**

4. National Best Timed Pathway

Discussion summary	JV updated the Board on the progress made since the last meeting and confirmed that work on this is progressing with the final pathway due imminently to be shared. Some of the diagnostic pathways remain to be challenging and that this is a national issue. The publication of this will be expected by the end of this year. This work has been running remotely so far with one vanguard event in London. RW enquired whether a deputy was required to support JV in this work and offered his services. This was welcomed by JV.
Conclusion	The Board noted the progress
Actions & responsibility	**CLOSED - FL made enquiries for a clinical deputy. The timescale for this initial piece of work is now finished awaiting publication. RW will be put forward when this piece of work recommences.**

5. OG Service and Prehab

Discussion summary	ZM introduced herself as the project manager to introduce the Prehab element to the pathway with John Moore (Chair of Prehab Board). This project is on its infancy to get patients 'as fit as possible' prior to treatment using physical activity focusing on (in the first instance) patients identified for surgery for OG/ HPB, lung and colorectal and in the future would extend to patients undergoing chemotherapy and radiotherapy where currently evidence is not so clear. She explained she wanted to work with OG colleagues via a preliminary workshop to identify how this would look. WM asked what the outcome measures were. ZM explained that this was in its infancy and that the funding for two years was to demonstrate effectiveness and the purpose of the workshop with as many disciplines as possible to scope this looks like for patients. It was stressed that ZM to reach the right people in the surgical provider trusts to be involved.
Conclusion	The board noted this update and imminent workshop in November.
Actions & responsibility	**CLOSED - FL/ZM to share details of a workshop scheduled for 20th November**

6. Pathology Report - Her 2 testing update

Discussion summary	This item has been on the agenda for a funding resolution. HER2 was requested up front by clinical oncologists on all diagnosis of adenocarcinoma as part of the work up for the sector MDT. All local trusts are now enquiring how this is funded as the number of requests and frequency has increased. WM explained this is NICE approved guidance who recommends that this is

	offered to patients for all non-resectable cancers /adeno carcinoma stage 4, type 2 -3 patients to determine the chemotherapy regimen at SMDT. This is also a requirement for trial patients coming through to have this test. As such this test is not one that is requested by the GM Surgical centre but is a National guideline to be done as part of the local diagnostic work up.
Conclusion	JV concluded that GMC pathway Board role is to ask local trusts to work up the patients with this test and for GMC to negotiate with central government on the funding of this.
Actions & responsibility	**CLOSED - FL/ JV to update Adrian Hackney and seek guidance and invite AH to next pathway board.**

7. 62 day review

Discussion summary	FL talked to the 62 day analysis slides on behalf of JF and the breakdown of the breach reasons. It was identified from the analysis that the main reasons are patient choice/ internal diagnostics/external diagnosis and co morbidities. The best timed pathway is looking to try and address this part of the pathway. A discussion took place over the various reasons for delays from a clinical oncologist and surgical point of view with the conclusion that we all need to be cognisant of what support is going on in the whole city and the reason why we are moving towards changing the OG system in Manchester. Treatment discussions need to happen in the same room at the same time at SMDT's around surgical or non-surgical options based on a patient's co morbidities and that patient should be involved in the treatment choices. EH felt that from a patient point of view the waiting for various diagnostic tests was the hardest, if this could be improved. Prehab was discussed as a consideration to help early stage OG cancers
Conclusion	This information is to be broken down to identify where the issues lie going forward.
Actions & responsibility	**JF to provide clarity around what the delay categories entail.**

8. Service Transformation and the single service

Discussion summary	JV updated the group on the current issues experienced so far: - • MDT attendance - some more work to do around getting everyone who is required there. • There is an increase in CNS numbers - happy to report that interviews are currently taking place. • OG specialty on call to match with emergency on call is a challenge working with healthier together plans. • Aware that information flow into and out of sector MDT's still need more work.
Conclusion	The board noted the update
Actions & responsibility	**No action for the group**

9. Research and Education update

Discussion summary	**Trial data** - WM queried the data contained in the trial report as it does not provide as much detail as it used to and there are trials missing. **Tumour samples** - WM informed the Board that he chairs the One

	Manchester group and that since centralisation there has not been any tumour sample at all sent for students. A discussion followed that the right conditions and process needs to be available for samples to be taken (pathologist, portering and the correct storage conditions) and the details **Surgical dependant trials** - to ensure there is equity across the board now that it is centralised and this needs to be sighted at Pathway Board.
Conclusion	The Board noted this development
Actions & responsibility	**CLOSED - FL to investigate source of the data report and review with WM** **WM to email JV with the details of the items raised.**

10. AOB - GMC Governance and Team Structure

Discussion summary	**Governance structure and the GMC Team Structure -** FL talked to the slides A query was made on the tenure of the membership of the team members and the pathway director's role and whether these were permanent or temporary positions. JV explained that subject to an annual director review and performance, he understood his position to carry over annually but will seek clarity. **Future meetings** - following discussions, it was agreed that the future meetings will alternate between The Northern and SRFT. **Jejunostyomy feeding tubes** - current OJ tube issues causing problems with maintenance and for removing.JV informed the group that the type of Jej tube used at MRI will be adopted at SRFT. JV informed the members that future patients for surgery with hickman lines will be taken out as a patient was cancelled due to infection causing a delay in her surgery. There was a discussion around correct side for portocath
Conclusion	The Board noted this development.
Actions & responsibility	**JV to check with Claire O' Rourke.** **FL to send out future meeting dates and venues.**