GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Urology Pathway Board

Pathway Board Meeting

Minutes of the meeting held on 11th September 2018

Seminar Room 1, Mayo building, SRFT

Members in attendance

Satish Maddineni (Chair)	**Pathway Director**	**Helen Johnson**	**CNS**
Mike Thorpe	**User representative**	**Euan Green**	**Consultant Surgeon**
Jane Booker	**CNS**	**Jacob Cherian**	**Consultant Surgeon**
Anna Tran	**Consultant Oncologist**	**Maryna Brochwicz - Lewinski**	**Consultant Radiologist**
George Yeung	**Radiologist**	**Steven Bromage**	**Consultant Urologist**
Tom Waddell	**Consultant Oncologist**		

In attendance

Rachel Allen	**GM Cancer**	**Kathryn Chamberlain**	**Transformation lead MRI**
Natasha Smith	**User Involvement manager**	**Jo Blood**	**SRFT**

Apologies:

Catherine Perry		**Tony Elliott**	
Amar Mohee		**Steven Elliott**	
Kathryn Chamberlain attending for Astrid Greenberry			

1. Welcome and introductions

Board members were welcomed. Members were invited to introduce themselves.

The Board were informed of James Leighton's retirement. SM noted that Rachel Allen was supporting the meeting today and that Fiona Lewis (FL) had been appointed to Pathway Manager for Urology and so will support the work of the pathway board going forward.

2. Minutes of the previous meeting and matters arising

Discussion summary	The Board were invited to review the minutes of the last meeting on 4 July2018. JB commented that Tom Waddell (TW) is incorrectly listed as a consultant surgeon, he is an oncologist.
Conclusion	The Board agreed the minutes as an accurate record of the meeting.
Actions & responsibility	FL – To amend minutes accordingly and publish on the GM Cancer website.

3. Living with and beyond Cancer - Recovery package

Discussion summary	**Recovery package and End of Treatment Summary** SM asked whether the recovery package work was now complete. The Board noted that a urology mapping event around the current practice had taken place with Lindsey Wilby (LW) and the urology nurses across the conurbation. During the event, the group had articulated the 'ideal vision' which has been signed off. KC commented that the mapping has been undertaken to look at the stages at which the eHNA can be done and the treatment summaries seem to be a key element of work for the Pathway Board along with the templates. The principal format has been agreed and accepted with some template differences between the trusts. There are 13 different treatment summaries at PAHT, the pathway board group was supposed to agree the templates once the CNS group had reviewed them. It was felt that it isn't as joined up as it could be and there are gaps of understanding and usage for end of treatment summaries across GM. Members in the group weren't sure whether this had been disseminated. The intention was for consultants/CNSs to be completing the treatment summaries. Following some discussion, it became apparent that many clinicians / CNSs are not aware that this is their responsibility though some are using end of treatments summaries as a last clinic letter to the GP.
Conclusion	eHNA and End of treatment summaries are a requirement across GM. The principle has been approved by the group with acceptance that there are some template differences. The current use and progress of these needs to be scoped, now that this piece of work has been ongoing over the past 16 months.
Actions & responsibility	**ACTION – KC to connect with Dan Burke to review MFT progress.** **ACTION – HJ to send prostate treatment summary docs to FL** **ACTION – FL to contact the urology nurses forum to scope progress of eHNA** **ACTION – FL to share a formal template with KC and board members**

4. Template Biopsy policy for GM

Discussion summary	JC informed the group that he has been working on standardising the protocol for GM and presented the draft copy and highlighted the key points. He informed the group that at PAHT the template Business case has been approved. There is variation in how it is currently being delivered across GM. There are areas where consensus needs to be agreed e.g the selection of patients, antibiotic policies by trust, the number of samples and from where, and financial constraints. SM summarised that a policy on template biopsy would be useful across GM
Conclusion	JC will send out to members to agree on a consensus on the SOP. JC will update the

	group as this progresses
Actions & responsibility	**ACTION - JC to present the Pathway standards at the next meeting. FL to send JC the GM Cancer blank template for pathway standards**

5. Sarcoma shared care pathway

Discussion summary	The Sarcoma shared care document was circulated to the group to check for accuracy. It was noted that this was not a shared care document but a pathway document. Following some discussion, it was noted that from a sarcoma and urology perspective, the clinical information is unchanged however the contact persons (namely MDT co-ordinator and clinical teams have changed).
Conclusion	The group has approved the clinical content however the contacts are to be updated.
Actions & responsibility	**Action - FL to work on updating the contacts and follows up with JB.**

6. Prostate pathway PID

Discussion summary	SM recapped and updated the progress of the Prostate PID to date. The work builds on the cancer vanguard programme which MBL and SB led. Overall, there is £10m for cancer of which the following has been proposed for phase 1 ○ Accelerated pathway in lung, prostate and colorectal cancer ○ CURE smoking Programme in secondary Care ○ ERAS+ and recovery package/ stratified FU. ○ I-Can shared decision making The prostate bid included an application for £750k over three years, and includes new posts, education, audit and research and is expected to be signed off on 13 September. The prostate pathway is an NHSE directive to be delivered by 2020. There is no extra resource for MR slots or scanners though there may be some up front funding for the extra demand in the short term. SM went through the new pathway to be implemented across GM. • STT mp-MRI where appropriate. • Co Coordinators will have an overview of clinic capacity and pathway overview. Navigators receive the TWW referrals for assessment, and if suitable patients are given an appointment for MR scan. • There will be dedicated uroradiology MR review reporting between 2-3 days. • The specialist hubs will be in the NE, NW, Stockport and Central. There was a query as to whether there was funding for the extra MR scans but unfortunately there will be no additional funding. A question was raised around how many patients the modelling suggested where

	an MR would not be required. SM confirmed that patients that are not suitable for radical therapy and based on co morbidities would not require an MR up front rather than putting an age on the criteria. MR capacity was discussed - Suggestions for dedicated scanners in the city were made but agreed that patients shouldn't have to travel far as this would increase DNAs and lateness. It was suggested that GM may have to buy temporary additional capacity via mobile vans. It was commented that all other tumour sites will want the same scanning and reporting 2-3 day turnaround reporting with concerns around impact over resource. This initiative will be a GM wide initiative so if necessary can take capacity from other units in a sectorised fashion. The pathway navigators would be key in the coordination of imaging.
Conclusion	
Actions & responsibility	**The PID and funding has been approved. The next steps will be the appointment of staff.**

7. Transformation Update

Discussion summary	A Joint clinic (surgical and oncology) has been sent up in Oldham. This has facilitated the transfer of surgical prostate cancer patients to the Christie for RALP. The implementation board are reviewing the following: **Organ specific MDTs** - It was noted that Daily MDTs across the city and splitting of tumour group will be challenging if not impossible. **Movement of surgical patients –** There has been no clinical consensus reached on the next steps for surgical implementation. It has been agreed that cystectomies & nephrectomies from the Christie should move to Manchester South (once MFT prostates have moved to Christies). Beyond this there has been no agreement for the transfer of patients. A discussion followed on the various ways of moving the service across GM. One option is to move in the surgical patients in a sectored fashion, and move the whole service across the city, whilst the other proposal is to move cases in small numbers based on the types of procedures (eg open nephrectomies followed later by laparoscopic nephrectomies). However, it was noted that it will be the same surgical team who do this covering two or three sites, The group were in unanimous agreement that the safest way to move a service across to another site is to move the service in a sectorised fashion moving the whole tumour group at the same time to minimise disruption and ensure the safe transfer of patients. . **Oncology SMDT perspective** - SM asked AT for an update on how the prostate MDT would function through the Christie. AT reported that there was limited progress as she was waiting on more detail from the Implementation Board. It would depend on organ specific MDT days and time. There was a discussion around whether oncologists and surgeons would want to be present for the discussion of their sector patients. If not there may be a risk in

	variation in care especially on a patient they the team had not met and not been present for the MDT discussion. The ultimate outcome of the whole process is to improve patient care - caution must taken to ensure that care is not compromised. It was agreed that a general consensus is needed by the oncologists on whether their preference is to work with general oncology input per sector or whether the preference is for the surgeon and oncologist for each sector to be present for the sectors MDT discussion. **Radiology view** - MBL expressed great concerns and explained the lack of radiologists resource to attend all the MDTs, prep cases and present/support so many MDTs with the danger of swamping the service without even thinking about site specific MDTs. The primary solution is for 1-2 radiologists to cover all the 60 - 7O cases - this would need some modelling on proposed numbers. It was noted that the preparation of 25 - 30 cases would need 4 hours of prep time and then need to add peer review support to look at scans in detail. For job planning it is said that almost as much time for prep as for the MDT. Ultimately, the drive is to move the surgery but to do this we also need to provide good quality radiology review. Added to this is the problem of the lack of MDT rooms and adjusting job plans. The implementation board are reviewing this currently.
Conclusion	
Actions & responsibility	**SM to update the group**

8. Research Update

Discussion summary	Not discussed - Carried forward
Conclusion	
Actions & responsibility	

9. CWT standards - 62 days compliance in urology

Discussion summary	JB introduced high level data. However tumour and site specific data would be more difficult to access. JB will contact Claire O'Rourke at GMC for additional data resource. 62 day compliance in GM is just over 80% collectively. It peaked in Q4 (17/18) and dipped to 70% in Q1 (18/19), at which point the whole of GM declined and failed to achieve the target. The breakdown of the breach analysis of every breach across GM indicated the biggest delay is internal diagnostic delay, followed by treatment delay and capacity issues for surgery. The group discussed data going forward and requested the following:-

	• Previous three Quarters for trend • Tumour detail, • Trust level data • 12 months trend • Number of breaches matched to referrals It was noted that common trends had been reviewed in OG in detail for delays over day 31 targets and had proved to be a useful exercise. SM felt this would be a useful bi-annually in Urology RA suggested Morris Tomlinson (MT) data analysist - cancer intelligence team who may be able to help improve quality.
Conclusion	All breaches should be reviewed internally
Actions & responsibility	**JB will check the number of breaches.** **JB to speak to MT for improved data.** **It was agreed that performance will be a running agenda item twice a year.**

10. Pelican MDT project

Discussion summary	SM informed the group that the Pelvic cancer charity who had worked with colorectal cancers over the past 30 years approached GM via the Vanguard project about the GM mp-MR project. They have previously organised MDT workshops to help disseminate trials and new pathways. A working group is being formed by Pelican with experts from all over the country. Pelican want to run a GM and Lancashire prostate MDT workshop in early February.
Conclusion	
Actions & responsibility	**SM will update**

11. Urology Clinical Trial Finder

Discussion summary	AT explained the clinical trials power point set for all the trials is available at The Christie only currently and so not yet available for those with no access to the Christie intranet This tool 'Urology SMART' gives hyperlink access to various clinical trials available on the internet. It was developed and kept up to date by the Urology research nurses. The group thought it was 'User friendly'. From a clinical point of view this was a good tool to access trial resource with all the criteria in one place. AN advised TW to speak to Damian McCaul to get renal trials in the same format. It was noted that this is a really useful MDT aid.

Conclusion	Please see attached for information on access to the website.
Actions & responsibility	**TW will liaise with Christie urology research team to get renal trials added.**

12. AOB

Discussion summary	**GM Cancer Structure** RA updated the Board on the recent changes to the GM Cancer team structure and described the new structure. **Governance Structure** The governance structure was shared with the Board for them to consider. The GM Cancer UI Team structure remains the same. **Transformation Fund** RA provided an overview of the plans for the GM Cancer transformation fund investment. RA described the projects in receipt of funding in wave 1 which includes: accelerated pathways for lung, prostate and breast; ERAS+, I Can. PIDs are currently being finalised. Investment allocations for each project will be signed off by Friday 14th September at the TF investment panel. RA informed the board to direct any queries in relation to the TF work to Fiona Lewis in the first instance. **User Involvement** No update
Conclusion	
Actions & responsibility	**ACTION - FL to look at commissioning representation on the pathway board.**

Date and time of next meeting:
15 November 2018 - Seminar Room 12 , Mayo Building, SRFT at 14:00- 12:00