

Greater Manchester **Cancer**

Oesophago-gastric Pathway Board

OG Clinical Pathway Board

Minutes of the meeting held on

29 November 2018

Members in attendance

Dr R Willert (Honorary Chair)	MUFT	Amanda Law	Bolton
Hamid Sheikh	Christie	Michelle Eden- Yates	SRFT
Sue Sykes	GM Commissioning	Martin Smith	Patient Representative
Louise Porritt	Stockport	Elaine Hayes	Patient Representative
Richard Keld	Wigan	Marc Abraham	Christie
Rachel Melhado	SRFT	Amanda Law	Bolton
Bohdan Smajar	Bolton	Julie Fletcher	Wigan

In attendance

Alison Armstrong	GMC	Mel Atack	User Involvement
Fiona Lewis	GMC		

Members sending apologies

Mr J Vickers	Salford (Chair)	Colin Jackson	Patient Representative
James Turner	Christie LWBC	Was Mansoor	Christie
Catherine Perry	Respect 21	Stephen Hayes	SRFT
Tina Foley	MFT (S)	Mr B Abduljalil	Tameside
Dr R Keld	WWL	Sue Liong	MFT (C)
Ms R Melhado	SRFT		

1. Welcome and introductions

In the absence of JV, RW is kindly chairing this meeting and invited attendees to introduce themselves. He welcomed MS who is attending the first time as a patient representative.

2. Minutes of the last meeting.

Discussion summary	These were accepted as an accurate record of the meeting. Actions are either on the agenda or closed with exception of Her2, a meeting is scheduled on 5 December between WM and SS GM Commissioner.
Conclusion	Board to note
Actions & responsibility	Her 2 to be itemised for January for update by SS

3. User Involvement update

Discussion summary	<p>MA welcomed MS to the group. She updated the group that there is potential for up to 120 people to be part of the User Involvement agenda in Greater Manchester. The UI community were asked for their three key priority areas and identified the following:-</p> <ul style="list-style-type: none"> • Earlier diagnosis • Faster treatment • Psychological support <p>The work of the OG board needs to complement this together with UI members to support key areas of work where user involvement can make the most impact and are involved in development and monitoring of these areas. For example,</p> <ul style="list-style-type: none"> • Comination leaflets to patients on the single service. • Continue work on treatment summaries • Patient follow up <p>The objective is to create a wider voice using the small communities that currently exists in Greater Manchester who we want to work with to develop elements of GM OG services.</p> <p>MA also stressed that there needs to be a sustainable plan for UI to have a 'business as usual approach' with a buddy system volunteer from this group to champion this agenda. MA invited interested volunteers to come forward.</p> <p>MEY informed the group that SRFT are holding upper GI patient/carer engagement event on 22 Jan for the Greater Manchester patients going through the service and is keen to work with MA to communicate the event.</p> <p>RW queried what GP communication regarding the single service is out there - SS confirmed that there is a GP lead (Sarah Taylor) and it is on her radar to keep all GP leads informed, there is a meeting on 23rd Jan for GP cancer leads in all CCG's and there is an opportunity at this meeting to cascade the single service information. SS will work with MEY for information.</p> <p>RW picked upon the third point for psychological support and strongly agreed this priority after a cancer diagnosis. MA informed the group that there is a psychological support pathway board. Majority of patients CNS can manage, but some need additional psychological support of which there is limited support and the work of this pathway board could help address and facilitate this need for OG patients.</p> <p>EH stressed that from a patient perspective, patients requiring low level support, waiting for appointments is a major psychological issue for patients and if this could be speeded up would really help. The Navigator role and being part of the patients' voice could be key and this could be included in the SRFT patient event.</p>
Conclusion	Work to develop communication on the single service across the whole spectrum from patients to GP's is needed.

Actions & responsibility	<p>Interested volunteers to contact MA to buddy up and support UI. SS to work with MEY on single service update for GP's. MEY to feedback from patient group on navigator role in psychological support to take forward. FL to explore how to take forward single service information for patients</p>
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4. Patient Impact form update

Discussion summary	<p>FL recapped that this was developed by the Gynae pathway board, where patients requested how they could input what was important to them to be considered at MDT and devised a questionnaire to pilot for three months. It was concluded following the pilot that some of the questions posed was too soon for some patients consider in depth. The form was revised to one question and re piloted. The question posed to the group is do we want this for our OG patients?</p> <p>Following some discussion around process (i.e. how often can these be submitted, how long patient would need to wait for response, what impact on MDT's?) that this would depend on each pathway, and concluded that this really depends on OG pathway for process. It was also debated whether this already happens, (addressing psychological and social aspects looking at patients holistically) and concluded this was already takes place by CNS's verbally, albeit through conversation about their care, but perhaps should formally document this and the eHNA capture this.</p> <p>AA suggested waiting until the end of the second pilot for feedback before any further progression.</p>
Conclusion	Board to note
Actions & responsibility	Await the results for the second pilot, and see what the additional benefits of this are.

5. Review of Membership and Future pathway focus

Discussion summary	<p>Most members wanted to remain on the pathway board. FL suggested that each Trust had a deputy so that they cover each other and the Trust would be represented.</p> <p>SS explained that a Commissioning manager from GM cancer with support from the CCG's and a GP is being sought to cover each of the pathway board.</p> <p>The group discussed a pre-hab representative to the group and discussed anaesthetists, possibly for an anaesthetist to be invited.</p> <p>Future Pathway focus - FL explained that the single service will become a business as usual agenda item and the future focus of this pathway board was opened out for discussion with the following suggestions as agenda items:-</p> <ul style="list-style-type: none"> • MDT reform and defining the Pathway Navigator role. • Diagnostics and National best timed pathway • Pre-hab programme • Access to research trials • Recovery package - ensuring equitable access. • eHNA and Treatment summaries • Standardisation of OG follow up within Greater Manchester • Palliative care provision for OG patients • Pathways in support services, eg, Nutritional assessment & support
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	<ul style="list-style-type: none"> • Auditing of the Single service. <p>For some of this work, for example, identifying the support services across GM, identifying where the gaps are, identifying where the challenges are and how this fits in with National pathways was being suggest. The support of the Pathway board is vital through endorsement of the ideal model including what specialist support services are available and needed.</p> <p>Auditing - RM advocated strongly the need for, the importance of and the huge opportunity for a service of this size, the need for a dedicated data collection manager. Numerous data is collated by various people across GM but we should have more of an overview to robustly gather data across GM and benchmarked against other three sectors before we bench mark nationally. E.g. effectiveness of treatment. 5 year survival by tumour stage resection rates, whether we are we offering endo therapy to the right patient etc.</p> <p>The board queried whether there was allowance in the Transformation work and in the service specification to allow for data to be collected.</p>
Conclusion	<p>The membership has been refreshed and the new commitment for each Trust to attend at least 4 out of 6 meetings.</p> <p>The OG board are in agreement that data needs to be collected and agree what and how we collect it.</p>
Actions & responsibility	<ol style="list-style-type: none"> 1. FL has invited Javed Sultan and have re-refresh the membership to include deputies. 2. JV to consider anaesthetist representative. 3. Post meeting update - a GP member still being sought for this pathway board. 4. FL requested that members to send any further suggestions for the pathway board. 5. FL/JV to find out whether any funding was set aside for data collection from the Transformation work and in the /Service specification and ask how to do this going forward

6. OG service and Pre-hab Workshop update

Discussion summary	<p>FL updated the outputs of the workshop:-</p> <ul style="list-style-type: none"> • Good attendance - 30+ people. • Pre-hab project funded for 2 years targeting lung/ colorectal / OG patients who may have up to 15 week window to do prehab. Targeting the OG group where it is the most effective. There were 3 presentations showing research evidence:- <ul style="list-style-type: none"> ○ Patients who have received pre hab receiving better outcomes in functional ability post op. ○ Importance of nutritional prehab to treat malnutrition, retain muscle mass and performance ○ CPET as a risk assessment tool • Less sarcopenia, anorexia, and weight loss. Nutrition and Exercise in the local community • Training for level 4 physical exercises. The ‘Can do’ is happening in Salford now. • Nutrition and psychological input to level 1 using e-platform / phone text messaging and social media to keep engagement and encouragement. • Linked to research/Data collection
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	<p>Next Steps:</p> <ul style="list-style-type: none"> • The pre-hab group to describe what does exercise looks like (what it involves, how much, how long etc) • Steering Group date on 5 Feb - OG members to attend. • Launch in April 2019 <p>With reference to nutritional support KO stressed the importance of assessment and nutritional support from the outset directing them through the pathway whether this is curative or palliative. Currently this is provided ad-hoc, with no screening at the moment. There is a good Salford model with dieticians in clinics to capture patients but not practiced GM wide and there is a great disparity in nutritional support services for this high risk group. She explained resources limited but could use telemedicine, telephone calls</p>
Conclusion	WM and ZM are members of the group with Javed Sultan now invited to this group to update going forward. Add nutrition as one of the pieces of work going forward, as this also forms part of the National Best timed pathway.
Actions & responsibility	FL has invited JS to future meetings FL to contact KO for dietetic information

7 Service transformation and the single service Update

Discussion summary	<p>National Best Timed pathway was presented and feedback and comments from Pathway Board members as follows:</p> <p>It was agreed the timescales were not dissimilar to the GM OG pathway</p> <p>Endoscopy 7 days and CT scan by Day 10 – Tight timescales and challenging</p> <p>No mention of HER2 in the pathway. This will inform patient treatment and has delayed the patient pathway if not done earlier on (at first endoscopy)</p> <p>Capacity issues for Endoscopy and Radiology Already over utilized and all Trusts in GM utilizing weekends Same day CT scans are not realistic for most centres. Capacity issues around room availability and workforce, (clinicians, endoscopists, radiologists and radiographers) Difficulty getting endoscopy within 7 days, getting the first endoscopy is the hardest part. Ring fencing appointments, happening in some but not all Trust in GM, and all specialities are now requesting ring fenced appointments. (But strong argument for GI as pathway more complicated).</p> <p>Quality issues - Hard tissue diagnosis to take - If endoscopy and scans are externally bought in, the quality biopsy hit rate is poor. Training nurse endoscopists to be cancer screeners can take a long time to train. A lot of patients fall into these lists as relatively well high volume.</p> <p>7- 28 days – certainly aspirational as the current wait for CT before booking a PET scan (the current wait is 7-10 days for PET).</p>
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	<p>Pathway co-ordinators are key Need Coordinators and Navigators - Identifying who should be prioritised and proactively managing and moving people along the diagnostic pathway. (4 key bottlenecks in PET EUS CT, Staging laparoscopy, CPEX). This person to push at key diagnostic points rather than wait for MDT for onward referrals. DNA. Late starts, booking and scheduling improved. There is a potential for some funding for OG pathway navigator and would be the main port of call for the patient . SS explained the ACE project, where the patient is the main point of contact for the patient.</p> <p>Day 42 - unrealistic Aspiration for joint clinical oncology and surgical meetings, Radiotherapy currently 4 week wait and cant refer until patient has had a scan. Chemotherapy also swamped. Immunotherapy and targeted therapy also challenged.</p> <p>Also discussed are challenges across the whole oncology pathway, planning scans, and chemotherapy slots. Aspiration is for joint oncology surgical clinics and Christies are currently working through the logistics to hold joint MDT around job plans.</p>
Conclusion	National best timed pathway currently feels aspirational and at points unrealistic and to be fed back to the national team.
Actions & responsibility	FL/JV fed back to National team.

8. 62 Day performance

Discussion summary	<p>The Q2 is not ready yet. JF talked to the slides which Morris had prepared on GM performance Key highlights:-</p> <ul style="list-style-type: none"> • GM achieved 14 days in one month only in the last 6 months, so achieving 7 days will be a real challenge. Difficult to see and where the issues are. • Treating more patients on the 62 day pathway and finding more cancer since NICE guidance changes. OG finding more than the threshold of 3%. • Increase in referrals in the past three years, though the 2017 total of 1586 was debated and queried that this included. FL to query with MT.
Conclusion	Board to note
Actions & responsibility	<p>Post Meeting Note The top section is number of referrals that state 'Suspected Upper GI Cancer' irrespective of whether cancer was diagnosed. The lower section shows the number of ALL OG cancer patients diagnosed and treated from any source of referral or any priority (TWW, Urgent, Routine) i.e. includes</p> <ul style="list-style-type: none"> • consultant upgrades where OG cancer wasn't initially suspected • OG diagnoses where a different cancer was initially suspected • Non-GP referrals.

9. eHNA and Treatment summary - where are we now?

Discussion summary	<p>The HNA and Treatment summary is to support patients diagnosed, living with and beyond a diagnosis of cancer and is detailed in various documents including National Cancer Strategy 2015 -20, NHS Operational Plan 2017-19, GM Cancer Plan). Macmillan has funded each Trust with a Recovery Package Manager some with a team and some not.</p> <p>Following a cancer diagnosis, each patient should be offered a holistic assessment within 6 weeks, which covers health, social or financial signposting and support with a care plan; this can be paper form or moving towards electronic form. The problem is that has been no resources (devices) provided to do this electronically. This was to support sharing of the HNA electronically across the system and for Macmillan who has supported this to capture the data but this has proven difficult to roll out and people are at different places for OG and it is not always suitable for people who are not IT savvy. We need to see where everyone is up to in Greater Manchester.</p>
Conclusion	<p>The National guidance is to do this electronically by 2020. The paper HNA is embedded but not the eHNA across the system. There is a feeling that the quality of eHNA is not as good a quality. Quality of the conversation to generate the HNA. Real benefit for Lindsay Wilby to update the members. A lot of issues experiences in rolling this out and there is huge capacity issues.</p>
Actions & responsibility	<p>Lindsay Wilby to be invited to the next meeting FL to send out a questionnaire to scope current HNA baseline</p>

10. Research and education update

Discussion summary	<p>Respect 21 - audit of single site service - CP not present. Trials report - WM not present but he has been in contact with NIHR and e invited to a meeting to work with each Pathway board to determine our requirements. RM is lead for trials on the surgical trials and queried what trials are included. OCCAMs will be replaced by ELIXER (Cambridge) replaced by 2020 right at the beginning of the pathway at endoscopy to be entered for trials for genetic tailored therapy recruiting and we need to think about how we recruit this challenging as a short period of time</p>
Conclusion	Should capture all trials
Actions & responsibility	RM and WM to liaise and meet with NIHR.

11. AOB

Discussion summary	It was observed that the use of abbreviations should be explained or provision to provide a list to help members understand the conversation at the meeting.
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