GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Oesophago-Gastric Pathway Board

Oesophago-Gastric Pathway Board Meeting
Minutes and Actions

Meeting time and date: 17 July 2019 10:00-12:00

Venue: Seminar Room 6, Mayo Building, SRFT

Name	Pathway Board Role	Organisation	
Jonathan Vickers	Pathway Director	GM Cancer	2/2
Fiona Lewis	Pathway Manager	GM Cancer	2/2
Elaine Hayes	Service User Representative	GM Cancer	2/2
Javed Sultan	Deputy Trust Representative	Salford Royal Foundation Trust	2/2
Abduljahil Benhamida	Deputy Trust Representative	Tameside and Glossop Integrated Care NHS Foundation Trust	2/1
Ganesh Rhdakhrisna	Trust Representative	The Christie NHS Foundation Trust	2/1
Michelle Eden Yates	Nursing	Salford Royal Foundation Trust	2/1
Kellie Owen	Allied Health Professionals	Salford Royal Foundation Trust	2/1
Julie Fletcher	Cancer Manager Representative	Wrightington, Wigan and Leigh NHS Foundation Trust	2/2
Christine Peel	Trust Representative	Wrightington, Wigan and Leigh NHS Foundation Trust	2/1
Ann Anderton	Deputy Trust Representative	Wrightington, Wigan and Leigh NHS Foundation Trust	2/1
James Turner	Personalised Care Representative	The Christie NHS Foundation Trust	2/1
Ashok Menon	Deputy Trust Representative	Stockport NHS Foundation Trust	2/1
Louise Porritt	Trust Representative	Stockport NHS Foundation Trust	2/1

In attendance

Name	Pathway Board Role	Organisation

Alison Armstrong	Programme Manager	Greater Manchester Cancer	2/2

Apologies

Name	Pathway Board Role	Organisation	
Martin Smith	Service User Representative	GM Cancer	2/1
Sye Sykes	Commissioning Representative	GM Cancer	2/1
Was Mansoor	Research Lead	The Christie NHS Foundation Trust	2/1
Bhodan Smajer	Trust Representative	Bolton NHS Foundation Trust	2/1
Sandra Greer	Deputy Trust Representative	Bolton NHS Foundation Trust	2/1
Rob Willert	Trust Representative	Manchester University NHS Foundation Trust: Oxford Road Campus	2/1
Hui Lee	Deputy Trust Representative	Manchester University NHS Foundation Trust: Oxford Road Campus	2/0
Sue Liong	Trust Representative	Manchester University NHS Foundation Trust: Wythenshawe, Trafford, Withington & Altrincham	2/0
Tina Foley	Deputy Trust Representative	Manchester University NHS Foundation Trust: Wythenshawe, Trafford, Withington & Altrincham	2/0
Roger Prudham	Trust Representative	Pennine Acute Hospitals NHS Trust	2/0
Zola McFarlane	Deputy Trust Representative	Pennine Acute Hospitals NHS Trust	2/0
Amanda Law	Radiology	Bolton NHS Foundation Trust	2/1
Hamid Sheikh	Deputy Trust Representative	The Christie NHS Foundation Trust	2/1
Stephen Hayes	Pathology	Salford Royal Foundation Trust	2/0
Morris Tomlinson	Business Intelligence	Greater Manchester Cancer	2/1
Richard Keld	Deputy Trust Representative	Wrightington, Wigan and Leigh Foundation Trust	2/0

1. Welcome and Apologies	
Discussion summary	JV welcomed members of the board to the meeting and introductions were made. A number of apologies were noted. ▪ JV was upset to hear of the sad news and wanted to express our gratitude posthumously to Marc Abraham for all his great work and input to the OG pathway board and the pre-hab project. ▪ JV also informed the board that it has come to his attention that Amanda Law has handed her resignation to seek pastures new; she has been fantastic and have been representing the board for over 6 years wishing her well. Another great loss to the board. A process to seek a replacement radiologist was discussed.
Actions and responsibility	Members to note. FL to email to cancer managers and pathway board members to circulate for expressions of interests for a radiology representative - closed

2. Minutes of the last meeting	
Discussion summary	A point in the Minutes of the last meeting was raised, clarification was made by EH that it was 'hospital staff' communicating with patients at the first point of diagnosis, to keep two weeks free for tests when in reality it was not realistic and it did not happen, it was not GP's (as stipulated in the draft). Minutes were signed off as an accurate summary of the meeting. Actions Update: ▪ Research update - a meeting took place between Steve Woby and Was Mansoor with main issues: o Recent breach in protocol, (this was subsequently resolved), o Responsibility and capacity for OG Research which had not followed when services reconfigured. No update since meeting. The trials poster was circulated. A discussion was held around patient and clinician awareness to ensure eligible patients are made aware of any trials that were suitable. ▪ HER2 update -JV has sent the requested information to SS that HER2 testing at source is around 550 new patients, if we test everyone with gastric and junctional cancer regardless of stage or co morbidity (or subsequent treatment plan). Best pathologists estimate of cost per test is between £160 – 200 per case. To take the upper limit of cost per case – this equates to a total cost of £110,000 for all of the GMOG practice. A discussion took place where AM is supportive of the clinical benefits but fed back (on behalf of the pathology department at SHH) that the cost of the tests for SHH is higher because it is outsourced, and that there were concerns that there may be other cancers requesting the same. JV requested AM to provide number of cases and the cost for SHH.
Actions and responsibility	FL to correct EH clarification and add minutes to the GM Cancer website - closed FL to chase SW for an update - closed AM to provide details as detailed to JV - closed

3. Care and responsibility of local palliative care patients at MRI	
Discussion summary	MEY wanted to highlight a few incidents with the management of some complex patients particularly between SRFT and MRI, where there were requests for the CNS team to see patients when it's not appropriate and suggested the need for a named clinician to take responsibility for these patients (currently patients need to be transferred to Salford for

	palliative care which is not the best things for the patient or relative). JV agreed that there are some other themes occurring particularly at MFT - Oxford Road which have been raised since the start of the Single service, particularly where the resource has not transferred across to the Single service since been absorbed into other work, with the same thing happening to palliative care. Following some discussion, gastroenterologists on call some local trusts takes responsibility for the patient, Patient doesn't need to be under a member of upper GI team at Salford. In some cases a CNS is appropriate. JV listed the following options:- 1. If urgent patients - on call team at SRFT. 2. Approach the surgical outreach clinics. 3. Don't need either of the above (mainly affecting MFT (Oxford), MFT (south) and The Christie. (where there used to be a surgical centre). This is the option where it is not properly sorted out. There was a discussion around a general misunderstanding amongst clinicians that there is no upper GI service at MRI. There is an informal agreement at MRI - but when these clinicians are on leave, there is no formal agreement. Elective admission for stents are discussed at Sector MDT, variable level of knowledge probably needs a more robust pathway. RG asked whether this is the role of the pathway navigators, JV discussed the issues and that the OG BTP and how this support CWT issues and data collectors where there is so much data collected at SRFT and The Christie. FL reminded the group that Anne Marie Rafferty - clinical director came to the board 12 months ago, the gap analysis is now complete, JV agreed that it would be good to invite her and for OG to have better integration with the palliative care board, though it is recognised that each Trust have good relations with their local palliative teams and there is no issue but it would be good to know what the over-arching strategy is.
Actions and responsibility	JV to write to MFT (Oxford) to request a responsible person to be accountable. FL to invite Ann Marie to the next board to provide an update - closed

4. **Hickman Lines**	
Discussion summary	MEY raised an issue from a recent CNS meeting whether there was a reason why a hickman line needs to be removed prior to surgery. This mainly affects patients who were on the FLOT regime A discussion followed that there was between 6-8 weeks between finishing FLOT and awaiting surgery before starting adjuvant chemotherapy again 6-8 weeks later which can be a long time. Whilst there are community services available to maintain the line, whether a protocol was needed. JS expressed that there are concerns with keeping it in that length of time with infection, risk of sepsis and thrombosis.
Actions and responsibility	JV to clarify position with medical oncologists

5. 62 Day performance	
Discussion summary	JF presented a piece of work which was done for Director of Ops which analysed the breakdown of each breach per Trust working on the theory that If we achieve 7 day we would reduce breaches. The following discussion arose following the analysis.

	• There is some inequality in that some Trusts policy state to wait for the results of one test before requesting another. It was agreed that this equity cannot exist and needs to be scrutinised and dealt with. In clinical oncology, as an organisation The Christie works to a defined minimal dataset where these tests need to be in place. SSH stated they are moving towards direct to test to relive pressure on clinics and trying to develop virtual clinic to triage with an OGD and CT booked on referral. • It was observed that the time from request for a PET to receipt of one is quick but it is the reporting that is the delay. AA reported that in lung, PET back log delay of 8 working days and the impact on reduced working time due to the Pension issue. The PET coming together as a centralised service, the members queried whether there is an update on their plan. • It is clear with the poor CWT performance across GM, it is diagnostics which is extending the pathway, a point was made that and without extra capacity, the additional manpower would not make a difference. AA clarified that eachTrust has a responsibility to ask for additional capacity within their local capacity plan. The pathway not asking for more tests, but to utilise what capacity we have better. However, members stated that across the system, it is clear that the demand has gone up, people surviving, with recurrence, the impact of ebus, there is a 30 % increase in Upper GI in TWW. And the demand for STT for lower GI's has also affected overall capacity.
Actions and responsibility	FL to ask each Trust the waiting time for PET - Wigan, MFT S, MFT Ox,

6. **Transformation Funds proposals**	
Discussion summary	JV informed board members that a proposal has been submitted for pathway navigators who will signpost and advocate for patients and their clinician through the pathway and play a pivotal role in ensuring timely information is ready for MDT and in providing real time information for patients waiting for diagnostics and being able to signpost and support them patients during their care pathway. Cancer managers have also been asked to provide resource requirements for the proposal
Actions and responsibility	To note.

7. Update from CNS forum	
Discussion summary	MEY provided the following update: ▪ **Single service patient Information** - MEY asked if we had agreed on a GM name as she was updating the information for the surgical information at the moment and will be using for the oncology information whether we had agreed a name. JV confirmed that we had always used 'Greater Manchester OG Service' which seemed to cover most services without being specific to oncology or surgery though the only problem is that this does not cover outside of GM) and suggested to email this out for

	consensus. ▪ The group have been looking at a patient leaflet providing the information once patient has been at SRFT of their care once they have been treated at SRFT and looking at a cancer treatment summary which will be given to patient and to their local centre as well. Not quite due for pathway board and user involvement. ▪ Developing information for clinicians a descriptor of the OG pathway and remit of referring Trusts might also be useful. ▪ Christie information will be reviewed and the relevant information pulled out to fit in the patient information leaflet
Actions and responsibility	MEY to email to cancer managers proposed name for a consensus. CNS group to start to look at clinical information(pathway and signposting)for OG referring Trusts

8. **OG service and Pre-hab update**	
Discussion summary	JS provided the following update : • As of 29 July, there were 40 patients participating on the programme with 6 patients going on to have pre-operative assessment. • Any patients with LTC (i.e. diabetes, are referred to GP's, Dietetics), and referrals made to smoking and alcohol cessation. • Most patients compliant - 2 patients refused to be involved. • Iron infusion has been added to the pathway. • Once they have their re staging scan, they get an appointment pre op CNS, dietician, therapy assistant and anaesthetic Surgery school. • Real progress has been made. Next steps are to set up a research trail.
Actions and responsibility	To note

9. **Clinical documents for review**	
Discussion summary	Progress of Guidelines were discussed **Barretts** - AM wanted to clarify a couple of questions which has been addressed by RW post meeting, this will be reflected in the final document. **Radiology** - approved on website **Nursing Guidelines** - approved on website. **Chemo and Radiotherapy** - GR have added a summary box raw data of outcomes of trials published as a guide. JV would like to circulate this to the surgeons for comments before approval. **Dietetics** - KO offered to work on a GM dietetic document, this was welcomed by JV.
Actions and responsibility	FL/JV to circulate this to the surgeons for comments - closed FL to provide KO with a template - closed

10. Standardised Follow up -protocol

Discussion summary	JV for next agenda
Actions and responsibility	

11. **Service transformation and the single service**	
Discussion summary	JV - consensus that the MDT's need to change and rationalise. A meeting was held and representation is needed and needs to be in sight of the pathway board. Four MDT's getting down to two MDT's. Implications for Wigan, SRFT, Bolton and PAHT, no appetite to change the date but to roll in into a more cohesive forum with clinical oncology commitment, Likely change of time or format for Wigan, SRFT, Bolton and PAHT.. JV urged to keep a look out for the next meeting and for this to be part of the pathway board agenda.
Actions and responsibility	MDT reform meeting - 30th August

12. Any other business	
Discussion summary	None expressed
Actions and responsibility	

Next Meeting:

28th November 2019

Seminar Room 10

Salford Royal Foundation Trust