Peninsula Cancer Alliance

Meeting of the Lead Cancer Nurses/Cancer Managers

Friday 22nd September 2017: 10:00-12:30

Lifton Farm Shop (Strawberry Fields Conference Room)

FREEDOM OF INFORMATION

This group will observe the requirements of the Freedom of Information Act (2000) which allows a general right of access to recorded information including minutes of meetings, subject to specific exemptions. No one present today had any objections to their names being distributed in the minutes.

Meeting Minutes (Approved 08.12.2017)

Reference	Notes
1.0	**Welcome and Introductions**
	Please refer to separate attendance record here.
2.0	**Minutes of the meeting held on 14th July 2017**
2.1	The minutes of the meeting held on 14th July 2017 were agreed as accurate (with minor amendments as noted below).
2.2	(10.0) Rab McEwan is the new Chief Operating Officer at Royal Cornwall Hospital NHS Trust.
2.3	(12.0) EW clarified that the breast pathway was being affected by a shortage of radiology consultants, not haematologists.
2.4	TG would like feedback on the action plan arising from the external review of Brain and CNS services at Plymouth Hospitals NHS Trust.
2.5	**Action**: SD to provide feedback.
3.0	**Declaration of AOB**
3.1	Nil declared.
4.0	**NHS South Cancer Pathways Improvement Collaborative-feedback from attendees.**
4.1	AA – said there were some really useful points raised. It was helpful to cover the basics as well as the way patients are tracked against 4 key targets. The need to look at pathway improvements from a patient perspective was also highlighted. It was useful to know each step of pathway and how long it took.
4.2	TG found some elements helpful; it was useful hearing from other Trusts. Patient focus is being lost due to the drive on performance so it was nice to discuss this. Difficulties with some cancer pathways were flagged, some of which are not necessarily the best pathway for patients.

4.3 TG found that the pathways are quite generic and do not consider circumstances and limitations of individual trusts.

4.4 There is a need to govern the pathway to ensure best possible care. It was useful to see how many people go through the pathway.

4.5 SD found the meeting useful but it could have been condensed and more specific to particular site difficulties.

5.0 **Microwave Ablation Services at Exeter-Current Position**

5.1 EW requested clarification on referrals, in particular, the requirements for referring patients to Exeter.

5.2 TG has spoken to the divisional director who recognises that there has been confusion with the processes and confirmed that communications would be sent out next week.

5.3 There is no change to the referral pathway. 31d subsequent will continue to be taken and there will be communications to make this clear.

5.4 Exeter is working with Plymouth who is reinstating their service so this should help with patient flow.

5.5 TG apologised for the confusion.

5.6 SD confirmed that PHT have started seeing liver (limited capacity/waiting list) and kidney patients, and were seeing lung patients at the beginning of the year (specific criteria/single site only), but there was no more capacity (for lung) so patients were being referred to Exeter. There are currently 2 radiologists, if the service expands, PHT will be able to take more patients.

6.0 **Lung Nodules and CWT Monitoring Guidance Proposal**

6.1 NK wondered if this information had been communicated to Cancer Services Managers or just the MDT leads for lung. It was confirmed that the document had been widely circulated.

6.2 It was agreed that there are some elements of the document that lack clarity and/or don't make sense. Bristol put forward a challenge last week, stating that the document did not reflect national guidance and should go back to NHSE.

6.3 TG said NHSE need to take responsibility as this is going against guidelines.

6.4 LK confirmed that we need to do the right thing for our patients and that this is an on-going conversation.

7.0 **Macmillan**

7.1 NK had been contacted by Macmillan to ask if they could meet with the Lead Nurses at the end of the LWBC meeting.

7.2 Representatives from Macmillan were invited to the meeting today, but

unfortunately none were able to attend.

7.3 It was agreed that Macmillan would be able to discuss learning and development with the Lead Nurses.

7.4 SD asked if MacMillan have done any training regarding support workers; TG has queried this as they have recently recruited a MacMillan funded member of staff; TG is waiting to hear.

7.5 It was agreed that Macmillan will be invited to future meetings.

8.0 **MacMillan Specialist Adult Cancer Nursing Workforce Census**

8.1 TG does not mind participating in the census but didn't find it particularly helpful last year.

8.2 SD agreed; the report wasn't very useful; couldn't use it for business planning or benchmarking. It would be useful if they could link it in to the work with lung but UCONS is already undertaking some work so would need to link in with this.

8.3 TG asked if it would be more meaningful to break down the data. TG would prefer to do a local census to enable benchmarking.

8.4 **Action:** NK will respond to MacMillan from the group in respect of this (Ed Murphy).

9.0 **100,00 genomes-updated presented by NK on behalf of Fiona Maddocks**

9.1 **Action NK** will forward the presentation to the group.

9.2 TG asked the group if they would like feedback around project in its entirety. There is a lot of education for CNS and TG feedback to FM that a lot of the education is very scientific, not about how it affects practice and what staff need to know.

9.3 TG asked if the group had seen the new modules, this addresses what it means from CNS perspectives.

9.4 FM focus is on pathology samples and the challenges associated with this. Work around margins of what can or can't be used is being rolled out.

9.5 FM has started work at NDDH and has made contact with Torbay.

9.6 SD said PHT are focussing on Biopsies.

9.7 TG said Exeter is now starting to look at lymph node biopsies to ensure that sample sizes are sufficient.

9.8 SD confirmed that PHT have started talks with the haematologists.

10.0 **Welcoming our new Tertiary Pathway Coordinator-Victoria Kennington (VK)**

10.1 VK was introduced to the group as the new Tertiary Patient Pathway Co-ordinator (based at PHT).

10.2 SD has made some slight amendments to the job description, outcomes are still being met.

10.3 VK will need to access data across the pathway for the patients.

10.4 VK has begun familiarising herself with the pathways and MDTCs, as well as developing communication SOP for neo-MDT for communication around this in order to improve communications back to GPs.

10.5 VK's main focus currently is on the lung pathway.

10.6 It was asked whether part of VK's role will be around service improvements.

10.7 KC said VK will predominately focus on 62d improvement but could potentially be flexible to improve other areas.

10.8 It was noted that NK has undertaken some helpful work on some of the tertiary referral pathways and that it would be good for NK to work with VK in order to work on key areas and identify where pathway improvements can be made.

10.9 EW advised that Torbay is holding a lung pathway event and suggested that VK attends; SD agreed that this would be useful. LK confirmed that there is a joint alliance meeting on 10th October in Taunton and asked if VK could also attend this too.

10.10 SD advised that VK needs to main her focus on tertiary pathways.

10.11 KC said they were looking at data coming in in respect of the lung pathway if anyone had any ideas or issues that on what VK could help with, it would be useful to know.

10.12 EW said a lot of 38 day breaches fall back to Torbay as they cannot get consultants in clinic. EW suggested all new patients go to Plymouth as standard with follow ups and Torbay.

10.13 SD agreed that if patients are delayed due to a lack of clinic availability then they should go straight to Derriford.

10.14 KC said Adrian was also looking at what happens to the patients before they come to PHT to be clear what is needed prior to surgery.

10.15 LK said this was all discussed previously and there would be some suggestions from this.

10.16 NK advised that the lung MDT pro-forma from North Bristol Trust was really useful.

10.17 SD said they do have a high risk MDT now at PHT who meet weekly to discuss high risk patients. If patients are anatomically suitable for surgery but either decline surgery, or cannot have surgery for another reason, they will meet the criteria for discussion at the high risk MDT.

10.18 PHT need to set a date for the MDT but Monday is the only time to get the team together. SD said that consultants should take patients to the high risk MDT themselves following refusal at local MDT.

10.19 EW has a meeting booked on 3rd October re lung pathway and asked TG whether anyone from RD&E could attend to talk about EBUS. TG asked for the details to be provided and will see if someone can attend.

10.20 SD suggested VK attends all hospitals some MDTS to feedback issues with tertiary referrals. TG said the lead lung consultant will have some queries and would like to link in with VK.

11.0 **AOB**

11.1 SD asked LK about the Alliance plans to appoint project managers to undertake some of the transformation work, and how they are going to help the providers. JM mentioned they would transform the lung pathway. SD wondered how they will be able to help.

11.1.1 TG said they know what issues Exeter face and have started to look at the lung pathway. TG was however unsure how they would be able to support achieving the NOLCP, noting that the clinicians are also feeling the same way.

11.1.2 TG said they need to be able to continue the work rather than start again with new staff (project managers).

11.1.3 SD said project management is useful for pushing matters forward but unless they are based in specific Trusts it is difficult for improvements to be taken forward.

11.1.4 TG was reassured by JM's emails but the team at the RD&E are under great strain and would not find it helpful to have to work with new people who are not familiar with their pathway.

11.1.5 TG raised concerns that members of staff may relinquish their current posts to go in to new roles which would leave them short staffed.

11.1.6 EW said she sees the project managers as a supportive role and can see the value of a network-wide post to be able to address the issues throughout the pathway but agrees that there should be designated days for those people to spend in certain Trusts. EW said they are lacking capacity to drive matters forward so it would be useful to have a person in post to take matters forward.

11.1.7 LK said there needs to be an overview of who is driving the work forward. And that there is continued scrutiny on how pathways are being implemented.

11.1.8 LK advised that posts had not been externally recruited as it was recognised that the post needs to be undertaken by someone who understands cancer

pathways. LK agreed that it would be better to base project managers within Trusts to facilitate direct working.

11.1.9 TG queried how these roles with dove-tail in to other roles. SD said there is a lot of scrutiny on how money is being spent and would like some clarity on what the recently acquired transformation funds would be spent on.

11.2 LK said some of the funds will be used to support the clinical leads, including having individuals based around the South West with funding to back-fill the roles. SD said the advertisement was not clear.

11.2.1 LK said that the FIT project will work slightly differently.

11.2.2 TG said there is a need to understand how to utilise what we are being given and how they work into these other roles.

11.2.3 SD asked if money can be split, LK said it doesn't have to be one person as long as we can see how they would work.

11.2.4 LK said it is a large geography which is why the post is for 1 WTE to be negotiable. NK asked whether this would be a link for VK and NK and raised concerns about duplication of work occurring.

11.2.5 NK said there needs to be a clear plan of who is doing what. TG agreed this is a good idea but just questions whether some money could be invested for NK admin support or thinking of it in different ways. NK started to do some scoping but is not employed for service improvement. NK said there are only certain points in the year where work becomes very admin-heavy so admin support may not be helpful.

11.2.6 LK also advised that an additional person could be used for cover when NK is away/admin capacity could be shared between us.

11.2.7 NK drives actions from the SSGs which can be challenging. It can be time consuming and therefore the Alliance would need someone who can set out clear plans and drive them forward.

11.2.8 SD asked if it would be possible to split the money to know what is available in the Peninsula to spend. LK asked who would be responsible for each area and who would hold accountability. TG said until we know what amounts are involved, it is it is difficult to know, but there is a lot of duplication is happening.

11.2.9 LK said it could be split but complications arise as to whose responsibility it is to write delivery plans.

11.3 Labs within the RD&E are ready to go with the FIT project but LK said there is more work involved. There is a draft plan but there is a need for someone to run with this.

11.3.1 Re lung and prostate LK agrees it may be more useful to look at this differently and if the group has proposals then it seems quite reasonable. LK said there is some flexibility with the money available. SD asked if anyone was willing to release someone for this proposed role, there was potential from the quality

improvement team at Torbay, potential for someone from the service improvement team at Cornwall but no one with cancer services experience.

11.3.2 Consultants are not happy as they see a need for money in order to help service improvements but cannot see the benefit of creating new roles.

11.3.3 LH said Cornwall would only be able to release someone part time. SD suggested this role be a band 7 instead of an 8a with Trusts sharing the person 1 day a week apart from the reporting Trust who would need the person for 2 days.

11.3.4 LK said if the role was broken down across Peninsula it will not look like a lot of money and asked whether this could be juggled within the bid. TG raised concern that the successful person will need to find their feet which will take time, be able to challenge teams but money was only available for 1-2 years and was unsure of what will actually be achieved.

11.3.5 Trusts are signed up to it but wonder how this role can be used to their benefit. SD said it either needs to be advertised within the Trust or money given to be used. LK asked if each Trust had someone available who can work on the pathway. AA agreed it would be easier to have someone already in the Trust to have protected time to work on the projects.

11.3.6 LK explained the importance of needing to work towards the delivery of the bids.

11.3.7 SD wanted to know how much money was available in order to advertise within the Trust and to decide which person has the most experience to allow an extra day to take overarching responsibility. LK asked whether there would be spare money in order to provide admin support. SD advised that as a Peninsular the workload could be arranged to ensure there is no duplication, and to see what would be available for admin support. NK said that it would be important to work closely with VK.

11.3.8 LK said as long as there are clear lines of accountability and reporting it didn't matter how the money is used for lung and prostate pathways, however, FIT is slightly different and would not work this way.

11.3.9 Re: Colorectal Pathway: LK advised that once the report from London comes in (after Christmas) it will make a massive difference to 2WW referrals as some patients are referred who do not fit the 2WW criteria and would be referred for FIT testing instead.

11.4 EW asked whether there is a planned change to the pathway for post take surveillance MRI and follow up. EW said nurses at Torbay were not trained for this follow up. EW asked whether there needs to be an agreed point for when patients return back to Torbay. SD and EW will discuss this.

11.4.1 TG said that Exeter has a WTE specialist palliative care consultant and WTE specialist palliative care nurse. There has been a reduction in lung emergency admissions and length of stays. This has also significantly improved quality of life and shows the need for education of management of those patients during their cancer care within the community.

11.4.2 SD asked whether the majority of care should take place in the community and TG said it is however there is the lack of services in the community. Multi-specialist approach has made a huge difference but is a significant investment. TG happy to share with others, LH said they need to look in to work around their service and would like get it right in Cornwall.

11.4.3 TB briefly updated the team re NDDH advising that Nathan Brasington has now left the Trust and his role is going out to advert externally. TB said in the meantime Emma Thoms, Lindsay Stanbury and herself will be backfilling the role.

11.4.4 Finally, EW queried the quality survey from Richard Gosney as it does not include outpatients in this survey so EW has gone back to him about this and said that this must be included. Also concerns that comments are not being anonymised.