

Meeting of the Lead Cancer Nurses/Cancer Managers

Friday 14th July 2017: 10:00-12:30

Lifton Farm Shop (Strawberry Fields Conference Room)

Attendance Record

Organisation	Name	Position
North Devon Healthcare NHS Trust (NDDH)	Nathan Brasington	Cancer Services Manager
Plymouth Hospitals NHS Trust (PHT)	Sian Dennison	Head of Nursing for Cancer/End of Life and Trust Cancer Service Manager
	Katie Caley	Senior Performance Information Analyst
Royal Cornwall Hospitals NHS Trust (RCT)	Ruth Card Louise Hunt Sarah Lear	Improvement Facilitator Cancer Services Manager Lead Cancer Nurse
Royal Devon and Exeter NHS Foundation Trust (RDE)	Tina Grose	Lead Cancer Nurse
Peninsula Cancer Alliance (PCA)	Nina Kamalarajan	Peninsula Cancer Alliance Manager
South West Strategic Clinical Network (SWSCN)	Jonathan Miller	South West Cancer Programme Lead
Torbay and South Devon NHS Foundation Trust (TSD)	Christine Bell (CB) Sam Brenton (SB)	Cancer Waiting Times Manager Lead Cancer Nurse
University Hospitals Bristol NHS Foundation Trust (UHB)	Jaime Cargill	Teenage Cancer Trust Lead Nurse
Apologies	Emma Thoms (NDDH) Emma Wheatfill (TSD) Alex Atkins (RDE) Lynne Kilner (SWSCN)	Clinical Matron Cancer Services Manager Cancer Performance Manager Peninsula Cancer Alliance Programme Manager

Meeting Minutes (as agreed 22.09.2017)

1 Welcome/Apologies Noted

See attendance list above.

2 Ratification of Minutes of Previous Meeting

The minutes of the previous meeting were considered and agreed.

3 Matters Arising

None raised.

4 100,000 Genomes Project Update (Fiona Maddocks)

(Refer also to presentation slides)

- 4.1
- Recent press briefing with Dame Sally Davies has really helped to raise the profile of the project.
 - A Genomics nurse was taken on in March; the programme aims to increase uptake.
 - There are a number of cancer pathways across the South West, the aim is to increase uptake in those areas with the highest patient flow.

4.2 Progress to Date

- First patient recruited in January 2016
- Recruitment end date is September 2018
- Target is to recruit 690 patients
- To date-165 patients, + 18 recruited to tissue bank (and when positive cancer histology comes through, patients can be approached to participate in retrospect).
- 5 of the 7 SW NHS Trusts are recruiting due to genuine capacity and infrastructure issues (especially histopathology).

4.3 Recruiting Cancer Patients/Consent Process

- Layer onto existing services/build into current practice.
- NHS England give £15 per consent conversation-this goes to the cancer leads to use at their preference.
- There has been some thought about bringing bank staff in to consent patients; this would be at the discretion of local teams and would only be available for the life of the project (Sept 2018).
- The importance of getting patients discussed in MDT/ flagging appropriate

patients for approach/consent.

- It is noted that the consent conversation is an issue (trying to identify members of staff who can make themselves available and it being a lengthy process).
- Training for consent takers- modules are available as is one to one consent training, and participatory training (which can support NMC revalidation).
- Doctors/Nurses/ODP consenting; it depends on infrastructure at each local trust, and who wants to do it.
- It was noted that the consent process is quite lengthy-this was feedback to the National Cancer Steering Group and it is hoped that the consent form will eventually be considerably shorter.
- Challenges too recruitment-eligible patients may not be flagged at MDT-clinical teams need to take responsibility to give patients equity of access should they wish to take part.

5.0 **Teenage and Young Adults (TYA)**

The RDE TYA post goes fulltime as of October 2017; consideration will be given as to how the post holder will link in to NDDH and TSD; the criterion for outreach also needs to be clarified; this will be more of a liaison with other CNS/CLIC social workers as opposed to a clinical role.

- 5.1 It was noted that there is no TYA cover in TSD and that they could be missing out on opportunities. There is also no direct support for NDDH; due to small patient numbers and limited funding. It was noted that the RDE TYA nurse will need to work with the existing teams at TSD
- 5.2 A Band 6 TYA Nurse has just been appointed at PHT.
- 5.3 The aim is to have consistency of TYA support across the region; patients should be flagged by teams early on.
- 5.4 Issues of safeguarding/governance were raised and it was recognised that this needs to be refined.

6.0 **Tertiary Referrals and breach allocation**

- 6.1 It was noted that IPT dates now have to be submitted; PHT have noted a varied difference in data compared to TSD. Referring back to the tertiary referral policy, it was noted that the IPT date should not be the date of transfer of information for each patient, but when the patient physically moves.
- 6.2 There was broad discussion about logging IPT dates and differing practices across the trusts; NK will work with trusts across the Peninsula to look at Tertiary Referral Pathways to identify where there are delays in the referral/IPT process, at what point

tracking is taken over and how avoidable delays can be improved.

- 6.3 JM confirmed that we need to resolve all issues and have complete clarity on this matter; Clinicians need to avoid unnecessary delays; i.e. writing referrals between consultants should not be the cause of a patient delay. We need to agree how services can be better delivered and what resources could help achieve this.
- 6.4 The importance of MDT Co-ordinators checking MDT outcomes was noted, as were the risks of patients getting “lost” in the system because trusts are not clear on who has responsibility for patient tracking at certain points in the patient pathway.
- 6.5 It was noted that MDT capacity is under strain, and that a particular focus on how the lung MDT functions is required to enhance a whole team approach.
- 6.6 TSD advised that there are delays in referring patient when consultants are on holiday without cover; and that sometimes patients are being referred elsewhere to avoid delays. JM is happy to raise this contractual issue for resolution.

7.0 **Brain and CNS**

- 7.1 There was an external review of Brain CNS services at PHT and an action plan has been submitted.
- 7.2 RCH will through business planning with Plymouth; how current service levels could be topped up were discussed and it was thought that the best approach might be telephone advice and guidance as opposed to on-site support.
- 7.3 It was noted there is no bespoke CNS service at TSD, the acute oncology service picks up most patients locally and liaise with the Brain CNS at PHT. TSD are setting up video conferencing which is hoped to be available in the next few months.

8.0 **Sponsorship of SSG Meetings**

It was agreed that NK will approach lead clinicians about “flat rate sponsorship” (whereby pharmaceutical companies sponsoring a SSG meeting would pay a standard rate); the benefit of this would be that sites that are not so attractive to pharma companies could benefit if the sponsorship funds were pooled and shared across all 13 sites.

9.0 **62 day update (Jonathan Miller)**

- 9.1 Money has been reallocated from the transformation fund to NHS England South to support investment in services in respect of recovering the 62 day standard. Providers with the poorest performance have been selected to receive additional financial support.

Peninsula Cancer Alliance

- 9.2 There is an expectation that PTLs should be reviewed internally, more than once a week and it was suggested to TSD that there should be daily performance meetings with service line managers and CEO; however, the reality of putting this into place may be very challenging.
- 9.3 JM confirmed that the PTL is now being analysed to project performance, and that there are some concerns regarding this. Trust approaches to PTL's vary; some are more accurate than others.
- 9.4 Of the £1.5m of funding available, approximately £150,000 has been allocated to the Peninsula; the priority will be to invest money in recovering the standard across the lung/prostate and colorectal pathway as these are where the highest volumes of breaches occur. It was proposed that how the money is to be spent would be up for discussion; it cannot be spent on capital; it may be helpful to see who is in a position to move onto a faster patient pathway and look at what sort of investment would help with this.
- 9.5 Separate funding has also been made available to recruit a band 5 MDT patient pathway coordinator/per trust. Discussions were raised with regards to the job description/banding and how this position will differ from the band 4 MDT coordinators. The post will be described as a pilot scheme and funding will be made available initially for 12 months.

10.0 **Alliance Update (Jonathan Miller)**

- 10.1 Devon STP have their own Cancer Board; this is in addition to the Peninsula Cancer Alliance Board; JM will raise this with regards to how this may affect the decision making process; As a comparator it was noted that the SWAG Cancer Alliance Board is made up of 2 members from each STP cancer board.
- 10.2 Tasks groups are to be set up for Lung (early diagnosis); possibly Colorectal (to resolve STT in endoscopy); and also prostate. The three groups will report to the early diagnosis group. A FIT group will also be set up to lead the implantation of FIT. The group will be South West wide with a variety of experts.
- 10.3 JM will write to the STPs regarding plans to make "every contact count" for diagnostic pathways in primary and secondary care.

11.0 **AOB**

Peninsula Patient/Public Engagement event: The plan had been to invite a number of people (patients/ public/charities) to agree what the patient approach to the alliance should be; however, response to this was disappointing. The event will now be held as a joint venture with SWAG.

12.0 Update by Trust

RCH

- Interviewing for an oncologist at the beginning of September.
- Rab McKeowan is also to take up post at RCH as Chief Operating Officer.

Torbay

- There is a shortage of haematology and oncology consultants which is affecting the breast pathway.
- Work on stratification is going well.
- A new breast cancer nurse has been recruited.
- There is some uncertainty within the trust at the moment due to re-structuring.

Plymouth

- Work to be undertaken on contracts to improve cancer waits.
- MDT effectiveness review completed, with evidence of some good practice going on.
- Oncology staff shortage.

RDE

- Enhanced supportive care (ESC)-we are finding interesting stuff coming out of the programme, where LWBC doesn't meet all needs, this programme does. Currently have 6 months of data, the next 2 years have been secured. Lung and Upper GI data shows reduction in admissions; the concept focuses on keeping patients well at home.

NDDH

- Availability of Oncology Consultants also an issue; 2 middle grades appointed, in transition, other post vacant.
- Information support centre build given the go ahead