Peninsula Cancer Alliance

Meeting of the PCA Gynae-Oncology SSG

Friday 13th October 2017

The Castle Hotel, Castle Green, Taunton

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.

Draft Notes (to be agreed at the next SSG meeting)

Chair-Khadra Galaal (KG)

Reference		Action
1.0	Welcome and Apologies-KG	
	Please refer to separate attendance list here.	
2.0	The minutes of the meeting held on 29th July 2016 were considered and accepted as an accurate record.	
2.1	It was agreed that there were no major changes to be made to the SSG constitution (other than to reflect the change in structure from Networks to Alliances).	
2.2	The first draft of the proposed shared network clinical guidelines has been circulated to the group via email for comments.	
2.3	The group needs to agree on documented patient pathways (as per peer review standards) to ensure clarity on patient flow is clearly set out.	
2.4	**Action**: NK to collate feedback on the proposed shared clinical guidelines and circulate the drafted patient pathways for comments/local service level amendments/variations.	**NK**
3.0	**Presentation**: Nina Kamalarajan: *"Cancer Networks, Cancer Alliances and Site Specific Groups: What's the difference, what's the point?"*	
4.0	**Sharing Best Practice** Streamlining Post-Menopausal Bleeding (PMB) referrals	
4.1	KG led a group discussion about how trusts across the Peninsula manage their PMB referrals.	
4.2	Cornwall receives a high number of PMB referrals (approximately 1200-1500/year) and as a result, delays in managing the volume of patients on the pathway became apparent.	
4.3	In order to streamline services, a "one stop clinic" was created to enable patients to attend clinic in the morning and have a same day biopsy or hysteroscopy.	
4.4	With this model of care, it is thought that patients could move along the pathway from referral to diagnosis within 14 days, however, a lack of Clinical Nurse Specialists severely limits the ability for this to be realised in Cornwall.	

4.5 It was highlighted that there is a lack of Gynae-Oncology expert commissioning guidance to support the relevant numbers of clinical nurses per patient population. Such recommendations (as recently published for Lung Cancer services) would be helpful to support a business case for services where there is a dearth of CNS provision.

4.6 The 62 day pathway has however improved and KG will shortly be in a position to present the results of how the service was implemented, to share with other trusts.

4.7 Torbay currently undertakes a scan/pipelle biopsy on patients with endometrial thickening; those with a positive biopsy go on to have a hysteroscopy.

4.8 In Taunton, there was previously a nurse led PMB clinic with scanning, however patients now have an examination or outpatient hysteroscopy. Consideration was given as to whether or not it would be possible to implement a "straight to test" model for this cohort of patients.

4.9 Previously in Exeter, ultrasound scanning had been available to GPs, however, their experience was that after the scan had been reported, nothing happened, and following an audit, it was evidenced that patients received direct from GP tests had a 4-6 week delay.

4.10 Concern was also raised as to whether or not patients are being examined-the risk being that they could have cervical cancer and this could potentially be missed. For this reason, patient examination must remain an integral part of the PMB service-however, this could be nurse led.

4.11 Exeter does not carry out pipelle biopsy; patients are triaged on the basis of endometrial thickness. Supporting audit evidence has shown that high numbers of patients who have a pipelle go on to have a hysteroscopy in any event.

4.12 It was acknowledged that trusts work differently to reach certain points along the pathway within a specified time; Trusts should utilise their strengths (such as hysteroscopists/sonographers) in order to meet the set goals.

5.0 **Clinical Guidelines**

It was agreed that gynaecology care across the Peninsula should be standardised in order to ensure equity of care for the population.

5.1 The British Gynaecological Cancer Society (BGCS) have published the following guidelines (updates due 2019):

1. Uterine Cancer Guidelines.
2. Ovarian Cancer Guidelines.
3. Vulval Cancer Guidelines.

5.2 **Action**: The group will adopt the above guidelines and consider using the ESMO guidelines for cervical cancer.

5.3 **Ovarian Cancer Referrals**

A discussion around tests in primary care for suspected ovarian cancer was raised. Practice varies in Exeter; GPs have access to scanning, some use it,

others do not.

5.4 In Cornwall, if the ca125 is normal and the patient has been examined by their GP, the GP will be advised to obtain a scan prior to re-referring the patient if the report indicates this.

5.5 It was suggested that the ultrasound scan can be the "1st appointment", but the clock still runs from point of GP referrals.

5.6 The referral proforma has been changed in Cornwall; however, the processes involved in doing this for Devon makes it very challenging. It is hoped that the new 2ww e-referral system will include an option for "advice back to GP" for inappropriate referrals.

5.7 It was thought that scanning prior to referral was the preferable option.

5.8 (Details on the current position of NICE in relation to the recognition and initial management of ovarian cancer can be found here);

1. Guidance 1.2-1.5.
2. NICE surveillance report 2016-Ovarian Cancer

6.0 **Research**

It was noted that uptake of trials across the Peninsula for gynaecological cancers is quite good, however; it was felt that coordination could be improved in respect of what trials are open and where. It is particularly difficult to coordinate rarer cancer trials.

6.1 **Action**: NK to liaise with Julie Cunningham to ascertain if there are any strategies that can be implemented to improve availability of information and coordination of trials. **NK**

6.2 Research updates (provided by Julie Cunningham) were shared with the group.

6.3 **Action**: NK to circulate the spread sheet of current open trials to the group. **NK**

8.0 **National Cancer Patients Experience Survey** (NCPES)

The recently published NCPES results demonstrate a wide variation in outcomes across the Peninsula (not specialist specific). It was suggested that at the next SSG meeting, each Trust brings information on the areas identified as requiring improvement-this will be particularly helpful to see if there are any similarities across the trusts in areas where the patient experience is not as good as it could be.

8.1 **Action**: NK to circulate an analysis of the NCPES (produced by Jonathan Miller-JM) to the group. **NK**

9.0 **Living With and Beyond Cancer (LWBC)**

9.1 The Peninsula Cancer Alliance has recently been successful in their bid for transformational funding to support implementation of the LWBC strategy.

9.2 The possibility to initiate a ca125 tracker was discussed; similar work on remote tracking has been successfully demonstrated for prostate cancer patients and PSA tracking.

9.3 Results of an American study demonstrated an increase in survival rates amongst patients whose follow up was self-directed.

9.4 JR gave an overview of the Alliance focus on prevention and early diagnosis and the role of secondary care teams, as well as the Making Every Contact Count (MECC) initiative (for further information on MECC please follow this link);

http://www.makingeverycontactcount.co.uk/

10.0 **AOB**

Nil

Next meeting:

Friday 20th April 2018 at Roadford Lakes, Broadwoodwidger, Devon.

Lunch will be served from 13:30, the meeting will start at 14:00 and finish 16:30/17:00.