Manchester Cancer

# Oesophago-gastric Cancer Pathway Board

## Annual Report 2015/16

Pathway Clinical Director: Mr Jonathan Vickers
Pathway Manager: James Leighton

**Version 3.0**

## Executive summary

The Oesophago-gastric (OG) pathway board is now a well-established and highly functioning board. It has representation from all stakeholder trusts with in-patient OG services, and key stakeholder OG service groups. It also benefits from having patient and GP representation present.

Over the last 12 months the board has been responsive, positive, and constructive. This assessment is borne out by the level of engagement provided to the Specialised Commissioners over the Greater Manchester OG oncology transformation process. The board will look to build on this over the next 12 months.

However the anticipated reconfiguration and the transformation process itself were a significant challenge to the board. Whilst the board did not allow this to distract them from their work, the board feels that they could achieve much more when the service is more effectively structured.

The board feel that they are well placed to support the commissioners and service provider or providers as an effective clinical body and look forward to fulfilling this function in the coming months.

Over the last 12 months the board has largely focussed on supporting the service transformation process across the conurbation. This year it has successfully –

- Reviewed the common pathway for all OG patients, and proposed amendments
- Developed and agreed a set of quality standards that define the future service in GM
- Won funding for a pre-habilitation programme for OG cancer patients

The board are proud of these key achievements which were undertaken during a period of uncertainty for all stakeholder organisations.

Looking forward to the next 12 months the focus of the board will be on supporting the service during a period of reconfiguration and transformation, by acting as an expert panel and an effective clinical body.

The board feel that the work undertaken so far in supporting the service has complemented this aim but feel that they now need to develop new functions and relationships with the single service and nominated lead provider.

On a related issue the board will agree the outcome measures or outputs that will be used to assess and monitor the service effectiveness along the whole pathway. This is a multi-organisation project and particularly challenging as the available data is limited.

The board will work to better support patients and carers living with and beyond their disease by ensuring a better understanding of the non-surgical elements of the pathway and designing appropriate supportive measures.

The board intends to continue to support the agenda of the early detection, prevention and awareness cross cutting group as well as look to work with to deliver the aims and objectives of each work stream of the GM cancer Vanguard..

In summary, in the coming year the board has identified the following key objectives:

- Agree the key clinical outcomes and outputs that will begin to define the service
- Provide the required level of support to the commissioning process to ensure an effective and IOG compliant service is established
- Agree a common follow-up process for all providers

The work of the board will not be limited to these objectives. As the year unfolds new challenges and opportunities will be identified. The board feel that as a high quality, dedicated, functioning group they are adaptable and capable of accepting and addressing all possibilities to deliver the objectives of Manchester Cancer.

The board are rightly proud of their achievements over the past twelve months and thank everyone who played a part in this success for their support and commitment.

# Introduction – the Pathway Board and its vision

This is the annual report of the Manchester Cancer Oesophago-gastric cancer Pathway Board for 2014/15. This annual report is designed to:

- Provide a summary of the work programme, outcomes and progress of the Board – alongside the minutes of its meetings, its action plan and it scorecard it is the key document for the Board.
- Provide an overview to the hospital trust CEOs and other interested parties about the current situation across Manchester Cancer in this particular cancer area
- Meet the requirements of the National Cancer Peer Review Programme
- Be openly published on the external facing website.

This annual report outlines how the Pathway Board has contributed in 2014/15 to the achievement of Manchester Cancer's four overarching objectives:

- Improving outcomes, with a focus on survival
- Improving patient experience
- Increasing research and clinical innovation
- Delivering compliant and high quality services

### 1.1. Vision

The overwhelming issue for the board over the next twelve months will be the development of a single world class OG oncology service across Greater Manchester and east Cheshire. This year the board has supported the commissioners through the transformation process and will continue do so over the next twelve months.

Over this period it sees its role as one of supporting any transformation by helping to establish the service and setting standards that take the new service beyond just achieving IOG compliance bur rather establishing a world class service. As well as being the focal point for patient and clinical engagement with the commissioning process.

The board accepts the challenge of early detection and prevention of the disease. It also sees itself as the body to exploit innovation, provide quality assurance of the pathway and be responsible for enhancing the experience of those living with and beyond their cancer. To this end it will collaborate with and support the GM Cancer Vanguard however possible.

The board will continue its work across the whole pathway and put in place actions where patient outcomes, survival rates and experience can be improved and enhanced.

### 1.2. Membership

| Trust | Nominee | Profession/ specialty |
|---|---|---|
| SRFT | Jonathan Vickers | Chair |
| | Colin Jackson | Patient representative |
| Bolton | Dr Amanda Law | Consultant Radiologist |
| | Mr Bohdan Smajer | Consultant Surgeon |
| Christie | Dr Lubna Bhatt | Clinical Oncology |
| | Dr Richard Hubner | Medical Oncology |
| CMFT | Mr Alan Li | Consultant Surgeon |
| | Dr Rob Willert | Consultant Gastroenterologist |
| East Cheshire | Dr Konrad Koss | Consultant Gastro-enterologist |
| Pennine | Julie Wolfenden | CNS |
| | Dr Regi George | Consultant Gastro-enterologist |
| | Mr Bashir Rameh | Consultant Gastro-enterologist |
| SRFT | Mr Ram Chaparala | Consultant OG surgeon |
| | Mrs Michelle Eden-Yates | Lead OG CNS |
| | Dr Stephen Hayes | Consultant Histo-pathologist |
| Stockport | Louise Porritt | CNS |
| Tameside | Mr Abduljalil Benhamida | Consultant Surgeon |
| UHSM | Mr Simon Galloway | Consultant Surgeon |
| | Tina Foley | Lead UGI CNS |
| | Dr Sue Liong | Consultant Radiologist |
| WWL | Dr R Keld | Consultant Gastro-enterologist |
| | Ann Anderton | CNS |
| Wigan CCG | Dr Liam Hosey | GP representative |

**Correct as at the May 2016 meeting of the board**

### 1.3. Meetings

Since the last report the pathway board met four times in 2015 and has met twice in 2016. The board have scheduled three subsequent meetings in 2016. Below are the dates of the pathway board meetings and the links to the board minutes.

31st July 2015 https://manchestercancer.files.wordpress.com/2014/09/og-pathway-board-meeting-minutes9.pdf

18th Sept 2015 https://manchestercancer.files.wordpress.com/2014/09/og-pathway-board-meeting-minutes10.pdf

27th Nov 2015 https://manchestercancer.files.wordpress.com/2014/09/pathway_board_minutes-27_11_151.pdf

11th December 2015 Extra-ordinary meeting to complete standard setting exercise – no minutes taken

29th January 2016 https://manchestercancer.files.wordpress.com/2014/09/pathway_board_minutes_29-01-16.pdf

27th May 2016 To be ratified at the July 2016 meeting

**Service user involvement**

Macmillan, in partnership with Manchester Cancer have funded a team to facilitate a User Involvement Programme of work that will establish a structure and platform for people affected by cancer to influence and steer the design of cancer services locally. The Oesophago-gastric cancer Pathway Board is now supported by a Macmillan User Involvement Manager who came into post in May 2015 and has been working to support the current Service User Representatives (SURs) on the Board.

Key objectives of the User Involvement team working across Manchester Cancer up to March 2017:

- To ensure at least one SUR on each Pathway Board representing the wider community and where there is already one, to recruit another.
- For each SUR to be fully involved and recognized as a substantive member of the board.
- To recruit patients and carers to form a wider community of people affected by cancer involved at different levels through coproducing a menu of opportunities.
- To develop a robust user involvement strategy for Greater Manchester & East Cheshire co-produced with SURs

**Progress**

Key developments with User Involvement within the Urology Board are detailed below:

- A second SUR has also been recruited to contribute to the work of the Board
- The SURs have been fully inducted through the User Involvement Programme, to ensure they have an understanding of the Manchester Cancer Structure they are feeding into and the involvement opportunities available to them.
- The SURs are also linked in with the User Involvement Steering Group where issues relating to the Board can be taken to gain the views of wider people affected by cancer.

**Priorities**

- Aligning SURs to be part of on-going projects
- To work to ensure that SURs at the Board are linked more widely with people affected by OG cancers to ensure the wider views are fed in.

**Attendance**

Holding board meetings within working hours will always be a challenge for clinical staff. However overall attendance has been pretty consistent and where non-attendance has been an issue the Pathway director has addressed it on a personal level.

The record of the attendance at each meeting to-date is in **appendix 1**.

**Educational meetings**

At this point in time the board has no more plans for any educational events as it is waiting for the cancer education strategy to be developed by Manchester Cancer. Once this strategy has been agreed the board will support and contribute to all urological cancer education as required.

## 2. Summary of delivery against 2015/16 plan

| No | Objective | Alignment with Provider Board objectives | Tasks | By | Status<br>Green = achieved<br>Amber = partially achieved<br>Red = not achieved |
|---|---|---|---|---|---|
| 1 | Develop service standards the help define the service | Objective no 1 & 4 | Complete and review by external clinical assurance panel of GM transformation | | |
| 2 | Organise an open meeting | Objective no 4 | Held as part of the standard development and assurance process | | |
| 3 | Agree the key clinical outcomes and outputs that will begin to define the service | Objective no 1 & 4 | To be completed once the service model is agreed and can be taken forward in collaboration with lead provider | | |
| 4 | Standardise the follow up process across Greater Manchester and East Cheshire | Objective no 4 | This will be taken forward as part of the GM Cancer Vanguard LWBC work stream | | |
| 5 | Assess the feasibility of introducing joint surgical and oncology out-patient clinics | Objective no 1 & 4 | On-going and dependant on a successful service transformation | | |
| 6 | Participate in a clinical study day | Objective no 3 | To be completed autumn 2016 | | |
| 7 | Work with provider Trusts to co-ordinate a response to the “suspected cancer : recognition and referral” NICE guidelines | Objective no 1 | Review completed and response provided | | |

# 3. Improving outcomes, with a focus on survival

### 3.1. Information

Oesophageal cancer is the thirteenth most common cancer in the UK. In 2011, around 8,300 people were diagnosed with Oesophageal cancer in the UK, that's 23 people every day. Oesophageal cancer is the eighth most common cancer in men in the UK, with around 5,600 new cases diagnosed in 2011 and the fourteenth most common cancer in women with 2,800 women were diagnosed.

More than 8 in 10 Oesophageal cancers occur in people aged 60 or over. Oesophageal cancer rates have risen by 65% in men and 14% in women since the mid-1970s.

Younger Oesophageal cancer patients have better survival rates than older patients. Overall, around 40% of people diagnosed with Oesophageal cancer survive the disease for at least one year after diagnosis.

Around 13% of people diagnosed with Oesophageal cancer survive the disease for at least five years after diagnosis. Ten year survival for Oesophageal cancer has trebled in the last forty years but it is still low. Around 1 in 10 patients are likely to survive their disease for at least ten years.

In 2011 in the UK, around 7,100 people were diagnosed with stomach cancer, that's more than 19 every day. Stomach cancer is the eleventh most common cancer in men in the UK with around 4,600 new cases in 2011. In the same period 2,500 women in the UK were diagnosed, making it the 15th most common cancer in females.

Around 9 in 10 new cases of stomach cancer occur in people aged 55 and over. Stomach cancer incidence rates in Britain have more than halved since the late 1980s.

Over the last 40 years five-year relative survival rates for stomach cancer have tripled. However Stomach cancer survival rates remain low with less than one in five people surviving the disease for five years or more.

See table 1 below for OG England cancer survival rates for patients diagnosed between 2009 and 2013.

| Women | | Women | | Men | | Men | |
|---|---|---|---|---|---|---|---|
| **1-year net survival%** | | **5-year net survival (%)** | | **1-year net survival%** | | **5-year net survival%** | |
| Cancer | | Cancer | | Cancer | | Cancer | |
| Melanoma of skin | 98.4 | Melanoma of skin | 92.8 | Testis | 98.3 | Testis | 97 |
| Breast | 96.4 | Thyroid | 88.7 | Melanoma of skin | 96.7 | Melanoma of skin | 86.8 |
| Hodgkin lymphoma | 93.1 | Breast | 86.7 | Prostate | 94.4 | Hodgkin lymphoma | 84.5 |
| Thyroid | 91.5 | Hodgkin lymphoma | 85.2 | Hodgkin lymphoma | 91 | Prostate | 84.4 |
| Uterus | 90.6 | Uterus | 78.1 | Thyroid | 88.8 | Thyroid | 80.5 |
| Cervix | 84.4 | Non-Hodgkin lymphoma | 70.3 | Larynx | 85.9 | Larynx | 66.2 |
| Non-Hodgkin lymphoma | 81.5 | Cervix | 67.4 | Rectum | 81.7 | Non-Hodgkin lymphoma | 65.2 |
| Rectum | 81 | Kidney | 60.8 | Non-Hodgkin lymphoma | 78.9 | Rectum | 59.2 |
| Myeloma | 78.1 | Rectum | 60.5 | Bladder | 78.6 | Bladder | 58.6 |
| Kidney | 76.2 | Colorectum | 58.2 | Myeloma | 78.3 | Colorectum | 58.5 |
| Ovary | 75.8 | Colon | 57.6 | Colorectum | 77.5 | Colon | 58.4 |
| Colorectum | 75.8 | Leukaemia | 49.4 | Kidney | 75.5 | Kidney | 57.6 |
| Colon | 74 | Myeloma | 49 | Colon | 75.3 | Leukaemia | 50.1 |
| Bladder | 67.1 | Ovary | 48.5 | Leukaemia | 69 | Myeloma | 47.1 |
| Leukaemia | 66.9 | Bladder | 47.9 | Mesothelioma | 45.9 | **Stomach** | **18.7** |
| Mesothelioma | 51.4 | Brain | 21.1 | Brain | 45.4 | Brain | 18.2 |
| Brain | 45.7 | **Stomach** | **20.9** | **Stomach** | **44.7** | **Oesophagus** | **14.3** |
| **Oesophagus** | **44** | **Oesophagus** | **17.1** | **Oesophagus** | **43.4** | Liver | 12.7 |
| **Stomach** | **43.5** | Lung | 15 | Liver | 34.1 | Lung | 11.1 |
| Lung | 38.9 | Mesothelioma | 11.7 | Lung | 33.2 | Mesothelioma | 5.5 |
| Liver | 32.3 | Liver | 10.6 | Pancreas | 20.4 | Pancreas | 5.2 |
| Pancreas | 22 | Pancreas | 5.6 | | | | |

**Table 1 – % Cancer survival in England – Adults diagnosed: 2009 to 2013, followed up to 2014**
*http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/cancersurvivalinenglandadultsdiagnosed/2009to2013followedupto2014* accessed 5th July 2016

### 3.2. Progress

The board will, when possible, audit outcome data for patients with OG cancer. It will subsequently agree what outcome measures it wishes to monitor. Ideally this will also include data from the Christie for those patients on a non-surgical element of the pathway.

### 3.3. Challenges

The biggest challenge to reporting on the outcomes of treatment, such as survival rates, has been getting access to Trust data for their cohort of patients. This is a consequence of working in an organisationally competitive network. It is anticipated that this challenge will be addressed by the eventual reconfiguration of the service and the development of the data work stream of the Vanguard.

# 4. Improving patient experience

### 4.1 Information

The 2015 National Cancer Patient Experience Survey for Oesophago-gastric cancer patients responding from Greater Manchester was published in July 2016. The survey contained responses from Central Manchester and The Christie NHS Foundation Trusts only.

The report from the 2015 National Cancer Patient Experience Survey for OG cancer patients can be found in the embedded document below.

UGI NCPES 2015.xlsx

A number of improvements had been made to the survey, from previous years. This means that caution needs to be applied when comparing this with previous surveys.

Due to the late publication of these findings the board has not had an opportunity to review this yet and will do at the next meeting of the board.

### 3.4. Progress

Due to the late publication of this report it is still to be reviewed by the pathway board. When it is the appropriate action plans will be constructed and added to the work plan of the board.

The board are confident that the service will continue to draw feedback from their patients. This underlines the commitment of the board and services to improve the patient experience and collect local data as well.

### 3.5. Challenges

It is difficult to draw any firm conclusions as this analysis is for all patients with cancer of the upper gastro-intestinal tract, which means that the Hepato-biliary cancer patients are also included and it is not possible to differentiate the responses from the two disease types.

The board feel confident that patient feedback will continue to support service delivery. They feel that by the nature of being an essentially two centre service and the experience of the MDT staff in undertaking such surveys that this challenge will continue to be met.

# 5. Increasing research and innovative practice

## 5.1 Information

Over 2014/15 the number of OG patients recruited into trials when compared nationally is as follows -

| Design type | | East midlands | Eastern | Greater Manchester | Kent, Surrey & Sussex | N East & N Cumbria | North Thames | North West Coast | North West London | South London | South West Peninsula | T valley & S Mids | Wessex | West Midlands | West of England | Yorkshire & Humber | Grand total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **CRN population (Millions)** | 4.4 | 3.3 | **2.9** | 4.5 | 3.3 | 5.4 | 3.7 | 2 | 3.1 | 2.2 | 2.7 | 2.7 | 5.6 | 2.4 | 5.3 | |
| | | | | | | | | | | | | | | | | | |
| Interventional | | 74 | 128 | **96** | 102 | 25 | 360 | 141 | 41 | 159 | 91 | 41 | 31 | 170 | 158 | 197 | 1814 |
| Observational | | 121 | 92 | **99** | 36 | 81 | 116 | 19 | 31 | 76 | 57 | | 96 | 78 | 9 | 256 | 1167 |
| Grand total | | 195 | 220 | **195** | 138 | 106 | 476 | 160 | 72 | 235 | 148 | 41 | 127 | 248 | 167 | 453 | 2981 |

The recruitment to trial by Trust over this period is below –

| Design | Short Name | CMFT | East Lancs | Pennine Acute | SRFT | The Christie | UHSM | WWL | Grand Total |
|---|---|---|---|---|---|---|---|---|---|
| **Interventional** | ABC-06: ASC alone or with mFOLFOX for advanced biliary tract cancer | | | | | 12 | | | 12 |
| | ABC08: Ph Ib Acelarin + cisplatin in advanced bililiary tract cancer | | | | | 2 | | | 2 |
| | Add-Aspirin | | | 2 | | 3 | 2 | 7 | 14 |
| | ATTACK-OG | | | | | 1 | | | 1 |
| | BioStent | | | | | 3 | | | 3 |
| | CANC - 3482 JANUS 1: Ruxolitinib or placebo + Capecitabine in pancreatic adenocarcinoma | | | | | 0 | | | 0 |
| | CANC - 3716 POLO1 Olaparib in gBRCA Mutated Metastatic Pancreatic Cancer | | | | | 1 | | | 1 |
| | CANC - 5097 | | | | | 0 | | | 0 |
| | CANC 4188 | | | | | 4 | | | 4 |
| | ESPAC-4 | | | | | 3 | | | 3 |
| | GO2 | | | | | 12 | | | 12 |
| | NCRN - 2446 Lenvatinib (E7080) vs. Sorafenib in First-LineTreatment of Unresectable HCC | | | | | 0 | | | 0 |
| | NCRN - 2724 LT extension study of Telotristat Etiprate (LX1606) | | | | | 4 | | | 4 |
| | NCRN512 masitinib vs sunitinib in gastrointestinal stromal tumour after imatinib progression | | | | | 1 | | | 1 |
| | NCRN640 Cabozantinib vs. Placebo in Subjects with HCC | | | | | 2 | | | 2 |
| | PANasta | 9 | | | | | | | 9 |
| | PLATFORM | | | | | 8 | | | 8 |
| | SIEGE | | | | | 4 | | | 4 |
| | SORAMIC | | | | | 5 | | | 5 |
| | ST03 | | | | | 11 | | | 11 |
| **Interventional Total** | | **9** | | **2** | | **76** | **2** | **7** | **96** |
| **Observational** | CTC in pancreatic cancer | | 76 | | | | | | 76 |
| | OCCAMS: Multicentre Study Determining Predictive Biomarkers & Targets for Oesophageal Adenocarcinoma | | | | 13 | | 10 | | 23 |
| **Observational Total** | | | **76** | | **13** | | **10** | | **99** |
| **Grand Total** | | **9** | **76** | **2** | **13** | **76** | **12** | **7** | **195** |

The complete NIHR 2015/16 Urology recruitment activity report is in the embedded document below.

OESOPHAGO-GASTRIC_Trials report_Year

### 5.2 Progress

Recruitment into clinical trials is a standing item on the agenda of each board meeting and the board reviews the recruitment levels within each organisation.

Dr Hubner, as research lead, has asked the NIHR for some more detail specifically in year on year changes and volumes of eligible patients.

### 5.3 Challenges

The three MDTs are very active in clinical research at a local level and regularly present and publish research. Some studies require very challenging streamlining of patient pathways to meet tight study timelines, and all the MDT functions cohesively to deliver this.

Recruitment relies not just on offering and conducting trials, but on having trials to offer. The MDTs and the board will do all they can to engage with Sponsors to ensure that all possible industry-sponsored and NCRN portfolio studies are available to the patients of Greater Manchester and East Cheshire, and that all suitable patients are considered for trial entry.

The board feel that the key to successful clinical research recruitment is that there is a co-ordinated front to the participation and will work to achieve that end.

# 6 Delivering compliant and high quality services

## 6.1 Information

Primary care practitioners will refer all patients defined by the "urgent, suspicious of cancer" guidelines for Oesophago-Gastric cancer to the contact point of a single named diagnostic or local team.

Local Oesophago-gastric teams provide local care for their own catchment area and collaborate on clinical decisions within sector-based MDTs with a full core complement of specialists. Patients will be treated in their own locality or at a specialist treatment centre, according to the decision of the MDT and by the appropriate specialist member of the MDT, in discussion with the patient.

The specialist Oesophago-Gastric Cancer teams and their catchment populations are as follows –

| Specialist Oesophago-Gastric Cancer Teams | SMDT Lead Clinician | Referring MDTs | Catchment Population |
|---|---|---|---|
| Central Manchester University Hospital Foundation Trust | Mr Alan Li | Central Manchester (including Trafford)<br>Stockport<br>Tameside | <br>452,291<br>301,096<br>241,875 |
| | | | **995,262** |
| Salford Royal NHS Foundation Trust | Miss Laura Formela | Salford<br>Pennine<br>Bolton<br>Wigan | 253,112<br>856,830<br>297,958<br>321,084 |
| | | | **1,728,984** |
| University Hospital of South Manchester NHS Foundation Trust | Mr Simon Galloway | South Manchester<br>East Cheshire | 168,678<br>204,353 |
| | | | **373,031** |
| **TOTAL** | | | **3,097,277** |

**Figures from [http://www.england.nhs.uk/wp-content/uploads/2013/12/ccg-allocation-big-table-v2.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/12/ccg-allocation-big-table-v2.pdf)*

The Christie Hospital is the tertiary referral centre for the region. Radiotherapy is delivered at Christie Hospital and the satellite radiotherapy units based at Royal Oldham Hospital and Salford Royal.

Some chemotherapy and clinical trials will continue to be delivered from Christie Hospital, although local chemotherapy is currently available at:

- Wigan
- Bolton
- Oldham
- East Cheshire
- Mid Cheshire

This service remains noncompliant with the objectives set out in the “Improving outcomes guidance”. This is a legacy problem and over the last decade there have been several attempts at reconfiguring the service.

The board has engaged with the NHS transformation team in Greater Manchester to support the latest process to try and resolve this issue. Their support involved drawing up a set of standards to define a future service, supporting the assurance process for these standards and providing a voice for the clinical community to help inform the commissioners.

The board remain optimistic that a new OG oncology service for Greater Manchester will be commissioned sometime in the next 12 months and will work with the commissioners and nominated provider or providers to ensure a world class Uro-oncology service is created and established.

### 6.2 Progress

The board has developed and implemented the following with the associated links attached

Common OG cancer pathway
http://manchestercancer.org/wp-content/uploads/2014/09/OG-Pathway-2015.pdf

OG cancer radiological guidelines
http://manchestercancer.org/wp-content/uploads/2014/09/OG-Radiology-Guidelines-2015.pdf

OG cancer pathology guidelines
http://manchestercancer.org/wpcontent/uploads/2014/09/revised_pathology_UGI_guidelines_final1.pdf

Protocol for the diagnosis and management of patients diagnosed with low grade dysplasia
http://manchestercancer.org/wp-content/uploads/2014/09/LGD_Barretts_Algorithm_OG_Cancer_Board_20151.pdf

### 6.3 Challenges

The absence of a reconfigured and transformed service remains to be a disappointment to the board. Whilst it did not disrupt the board from fulfilling its role, the underlying organisational distraction and lack of clarity on the future service was always present.

This challenge of non-compliance will remain and the board intends to continue to support the commissioning process to ensure that a single standardised uro-oncology service is established.

The board intends to be innovative and work with all stakeholders and providers of the service so that there is an increase in research participation, improved patient experience as well as patient survival and outcomes.

## Objectives for 2015/16

The board has identified the following seven objectives for 2105/16 -

1. Standardise and optimise follow up care for oesophago-gastric cancer patients
2. Feasibility study into running joint surgical and oncological clinics across the conurbation
3. Confirm the key clinical outcomes to be measured for Oesophago-gastric cancer

The work of the board will not be limited to just these objectives. As the year unfolds new challenges and opportunities will be identified.

The board feel that as a high quality, dedicated, functioning group they are adaptable and capable of accepting and addressing all possibilities to deliver the objectives of Manchester Cancer.

# 7 Appendix 1 – Pathway Board meeting attendance

| NAME | ROLE | TRUST | 31 07 2015 | 18 09 2015 | 27 11 2015 | 29 01 2016 | 27 05 2016 |
|---|---|---|---|---|---|---|---|
| **Mr J Vickers** | **Pathway Director** | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Colin Jackson | Patient representative | | ✓ | Apologies | Apologies | ✓ | ✓ |
| Dr Liam Hosey | GP representative | Wigan CCG | ✓ | Apologies | ✓ | ✓ | Apologies |
| Dr Amanda Law | Consultant Radiologist | Bolton | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr Bhodan Smajer | Consultant Surgeon | | Apologies | Apologies | Apologies | Apologies | ✓ |
| Mr Joseph Varghese | Consultant Surgeon | | Apologies | Apologies | Apologies | Apologies | |
| Dr Lubna Bhatt | Clinical Oncology | Christie | ✓ | ✓ | ✓ | Apologies | ✓ |
| Dr Richard Hubner | Medical Oncology | | Apologies | ✓ | ✓ | Apologies | ✓ |
| Mr Alan Li | Consultant Surgeon | CMFT | Bilal Alkhaffaf | ✓ | ✓ | Apologies | Apologies |
| Dr Rob Willert | Consultant Gastro-enterologist | | Apologies | ✓ | ✓ | ✓ | ✓ |
| Dr Konrad Koss | Consultant Gastro-enterologist | East Cheshire | Apologies | Apologies | ✓ | Apologies | Apologies |
| Dr R George | Gastroenterology | Pennine | ✓ | ✓ | ✓ | | |
| Mr Bashir Rameh | Consultant Surgeon | | Apologies | Apologies | ✓ | Apologies | ✓ |
| Julie Wolfenden | CNS | | Apologies | Apologies | Apologies | Apologies | ✓ |
| Miss Rachel Melhado | Consultant Surgeon | SRFT | Apologies | ✓ | | | |
| Mr Mr Ram Chaparala | Consultant Surgeon | | Apologies | Apologies | ✓ | ✓ | Apologies |
| Mrs Michelle Eden-Yates | OG CNS | | Apologies | ✓ | ✓ | Apologies | Apologies |
| Dr. Stephen Hayes | Consultant Histo-patholgist | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Louise Porritt | OG CNS | Stockport | Apologies | Apologies | ✓ | ✓ | ✓ |
| Mr Abduljalil Benhamida | Consultant Surgeon | Tameside | Apologies | Apologies | ✓ | ✓ | ✓ |
| Andrew Macdonald | Consultant OG Surgeon | UHSM | ✓ | Apologies | Apologies | ✓ | |
| Mr Simon Galloway | Consultant Surgeon | | | | | | ✓ |
| Tina Foley | Lead UGI CNS | | Apologies | Apologies | Apologies | Apologies | ✓ |
| Dr Sue Loing | Consultant Radiologist | | Apologies | Apologies | ✓ | Apologies | Apologies |
| Dr R Keld | Consultant Gastro-enterologist | WWL | ✓ | ✓ | Apologies | Apologies | Apologies |
| Ann Anderton | Cancer Nurse Specialist | | Apologies | Apologies | ✓ | ✓ | ✓ |

# 8 Appendix 2 – Pathway Board Annual Plan 2016/17

**9 Oesophago-Gastric Pathway Board Annual Plan 2014-15**

| | |
|---|---|
| **Pathway Clinical Director:** | Mr Jonathan Vickers |
| **Pathway Manager:** | James Leighton |
| **Date agreed by Pathway Board:** | To be ratified at the July 2016 meeting of the board |
| **Date agreed by Medical Director:** | |
| **Review date:** | January 2017 |

**Summary of objectives**

| No | Objective | Alignment with objectives |
|---|---|---|
| 1 | Standardise and optimise follow up care for prostate cancer patients | • Improved and standardised care<br>• Living with and beyond cancer and supportive care |
| 2 | Feasibility study into how possible it is to run joint surgical and oncological clinics across GM | • Faster and better diagnosis<br>• Improved and standardised care |
| 3 | Confirming the key clinical outcomes to be measured for Oesophago-gastric cancer | • Improved and standardised care<br>• Research and education |
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# Oesophago-gastric annual plan 2016/17

**Objective 1:**

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| **Aim:** | By March 2017 the board will have a plan to standardise the delivery of follow up aftercare for OG patients across Greater Manchester, so that all follow up care is the optimum care for that patient. |
| **Driver(s) for the change:** | By doing this work our patients will have an enhanced patient experience and safer care as any variation on aftercare between providers will be removed. |
| **Domain:** | Improved and standardised care<br>Living with and beyond cancer and supportive care |
| **Risks to success:** | Resources and time to complete the project.<br>Lack of engagement by providers |
| **How will any risks be mitigated?** | The board will collaborate with the LWBC work stream lead of the Vanguard programme and look to draw on their expertise and capacity. |
| **Support required:** | Leadership and executive level support<br>Integration with the Vanguard programme office |

| **Outline Work programme** | | |
|---|---|---|
| **Action** | **Resp.** | **By (date)** |
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## Oesophago-gastric annual plan 2016/17

**Objective 2:**

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| **Aim:** | By March 2017 the board will know how feasible it would be to run joint surgical and oncological clinics across the conurbation |
| **Driver(s) for the change:** | Currently those patients that are required to see a surgeon and an oncologist do so on different dates and in different locations. By running joint clinics it is hoped that the decision making will become more streamlined and lead to a better outcome and patient experience. |
| **Domain:** | Improved and standardised care<br>Research and education |
| **Risks to success:** | Time and other commitments of involved personnel<br>Lack of data sharing by organisations |
| **How will any risks be mitigated?** | Executive support as identified and required |
| **Support required:** | Leadership and executive level support |

| **Outline Work programme** | | |
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| **Action** | **Resp.** | **By (date)** |
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## Oesophago-gastric annual plan 2016/17

**Objective 3:**

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| **Aim:** | By March 2017 the board will confirming the key clinical outcomes to be measured for Oesophago-Gastric cancer |
| **Driver(s) for the change:** | The generation of meaningful outcome measures to facilitate national and international comparison, and year on year comparison of our own outcomes. This will ensure that the patient care delivered compares favourably with other centres and identify areas where care might be improved. |
| **Domain:** | Improved and standardised care<br>Research and education |
| **Risks to success:** | Resources and time to complete the project.<br>Lack of engagement or agreement by SMDTs and other stakeholders |
| **How will any risks be mitigated?** | |
| **Support required:** | Leadership and executive level support as well as the co-operation of the data work stream of the GM Cancer Vanguard |

| **Outline Work programme** | | |
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| **Action** | **Resp.** | **By (date)** |
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## Oesophago-gastric annual plan 2016/17

**Objective 4:**

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| **Aim:** | |
| **Driver(s) for the change:** | |
| **Domain:** | **Prevention, screening and early detection**<br>**Faster and better diagnosis**<br>**Improved and standardised care**<br>**Living with and beyond cancer and supportive care**<br>**Research and education** |
| **Risks to success:** | |
| **How will any risks be mitigated?** | |
| **Support required:** | |

| **Outline Work programme** | | |
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| **Action** | **Resp.** | **By (date)** |
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## Oesophago-gastric annual plan 2016/17

**Objective 5:**

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| **Aim:** | |
| **Driver(s) for the change:** | |
| **Domain:** | **Prevention, screening and early detection**<br>**Faster and better diagnosis**<br>**Improved and standardised care**<br>**Living with and beyond cancer and supportive care**<br>**Research and education** |
| **Risks to success:** | |
| **How will any risks be mitigated?** | |
| **Support required:** | |

| **Outline Work programme** | | |
|---|---|---|
| **Action** | **Resp.** | **By (date)** |
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