GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Agenda

Meeting time and date: 8.00am-9.30am Friday 12th January 2018

Venue: Frank Rifkin Lecture Theatre, Mayo Building, SRFT.

Chair: Rob Bellingham (deputising for Richard Preece).

#	Item	Type	To	Lead	Time
1	Welcome and apologies	Verbal	-	Rob Bellingham	5′
2	Minutes of the last meeting	Paper 1	Approve	Rob Bellingham	
3	Action log and matters arising	Paper 2	Note	Rob Bellingham	
4	Update from GM Cancer User Involvement Steering Group	Verbal update	Note	Sarah Haworth Nabila Farooq Ian Clayton	15′
5	Greater Manchester Cancer: Vanguard Innovation update	Presentation Paper 3	Update	Jenny Scott	20’
6	Lung Health Checks: update report	Presentation Paper 4	Update	Gunjit Bandesha/ Rachel Allen	15’
7	62 day report: Cancer lead review of cancer systems in GM	Paper 5	Update	Dave Shackley/ Susi Penney	15’
8	Resourcing the GM Cancer Plan and infrastructure	Verbal update	Update	Adrian Hackney	15’
9	HMDS external review: report	Paper 6	Approve	Dave Shackley	5’
10	**Papers for Information** ▪ Cancer Plan: cancer intelligence report/ cancer Plan millstone update	Paper 7 Paper 8	Update Update	Adrian Hackney Adrian Hackney	
11	Future Meeting Dates: Frank Rifkin Theatre, SRFT, ▪ **9th February 2018** 8-10am ▪ **9th March 2018:** 8-10am ▪ **4th May 2018:** 8-10am ▪ **13th July 2018:** 8-10am ▪ **7th September 2018:** 8-10am				

Please note the additional February meeting above.

Paper number 1

Greater Manchester Cancer Board

Minutes of the meeting

Friday 3rd November 2017, Frank Rifkin lecture theatre, SRFT

In attendance

GM Health & Social Care Partnership Team		Richard Preece	RPre	Executive Lead for Quality, GMHSC Partnership (Chair)
NHS England/ presentation on personalised care		Hilary Garrett	HG	Director of Nursing, NHS England / Deputy Chief Nursing Officer, England
Lead CCG		Nigel Guest	NG	Chief Clinical Officer, NHS Trafford CCG
AGG of CCGs		Rob Bellingham	RB	Director of AGG of CCGs
Provider Trusts	Salford	Jack Sharp	JS	Director of Strategy
	Central Manchester (MFT)	Caroline Davidson	CD	Associate Director of Strategic Development
	Stockport	Ann Barnes	AB	Chief Executive
	The Christie	Fiona Noden (for Roger Spencer)	RS	Chief Operating Officer
	Pennine Acute	John Calleary (for Roger Prudham)		Clinical Cancer Lead
Patients effected by Cancer		David Makin	DM	-
Patients effected by Cancer		Nabila Farooq	NFar	
Patients effected by Cancer		Ian Clayton	IC	
User Involvement GM Cancer		Sarah Howarth	SH	Macmillan User Involvement Programme Manager
GM Director of PH Transformation		Jane Pilkington	JP	Head of Public Health Commissioning
Medical Director – GM Cancer		David Shackley	DS	Medical Director, Greater Manchester Cancer
Director of Commissioning – GM Cancer		Adrian Hackney	AH	Director of Commissioning – GM Cancer, NHS Trafford CCG
Vanguard Innovation Programme Director		Jenny Scott	JSc	Programme Director, Greater Manchester Cancer Vanguard Innovation
NHSE Specialised Commissioning		Louise Sinnott (for Andrew Bibby)	LS	Head of Place Based Commissioning –

			Greater Manchester
Macmillian Cancer	Tanya Humphreys	TH	Macmillan Services Programme Manager
Nursing Lead	Dawn Pike (For Cheryl Lenney)	DP	Director of Nursing, MFT
VCSE Advisory Group representative	David Wright (for Donna Miller)	DW	Lead Nurse TYA, Christies
MCRC and Christie Hospital	Rob Bristow	RBris	Chief Academic Officer, MCRC
Christie Hospital School on Oncology	Cathy Heaven (for Richard Cowan)	CH	Associate Director, Christie School of Oncology
GM Cancer	Claire O'Rourke	COR	Senior Manager, Greater Manchester Cancer
62-day Presentation	Susi Penney	SP	Pathway Director head and Neck GM Cancer
Genomics presentation	Fiona Blackhall	FB	Professor of Thoracic Oncology, University of Manchester
Genomics presentation	Bill Newman	BN	Professor of Genomic Medicine, University of Manchester
Genomics presentation	Anne Armstrong	AA	Consultant Medical Oncologist, The Christie
Screening Presentation	Christine Khiroya	CK	Senior Screening& Immunisation Manager, Nurse Consultant
Darren Griffith, Cancer Commissioning Trafford CCG		Catherine Perry, University of Manchester	
James Leighton, Greater Manchester Cancer		Ryan Donaghey, Provider Federation Board	
In attendance		Dutch Delegates observing the Cancer board	

1. Welcome and apologies

RPre welcomed members and apologies were noted. RPre welcomed all guest and speakers to the board including the Dutch Delegates in attendance to observe the GM Cancer Board as part of a 2-day visit to GM.

2. Minutes of the last meeting

The board approved the minutes of the meeting on 9th September 2017.

3. Action log and matters arising

The board noted the action log. It noted that all actions were complete or on the agenda.

4. Update from GM Cancer User Involvement Steering Group

DM discussed that the steering group met on 2nd November. DM requested an update on bisphosphonates and the funding allocation to this. DM had spoken to DG from Finance prior to cancer board meeting and was given some assurance around this. AH also updated on the situation regarding bisphosphonates and action was being taken on this.

DM highlighted some concerns regarding the Acute Oncology paper and the viability of Metastatic Spinal Cord Compression Service (MSCC). Claire Mitchell, Acute Oncology Pathway Director is addressing this as part of the service specification.

RPre welcomed the new Patient User representative Ian Clayton and Sarah Howarth, Programme Manager for Macmillan User Involvement Programme to the board.

5. **GM Screening Programme Update**: Presented by Jane Pilkington and Christine Khiroya.

JP presented an update on the current screening Programme in GM, which has been supported by devolution in GM and Vanguard programme of work which has provided an opportunity to be innovative and test new ideas. They have commissioned a behavioural insight group to review the programme to develop a plan for engaging with the population in a way that has not been achieved in the past, in line with taking charge ambitions. The aim is to increase participation and uptake of the screening programme in GM.

The team acknowledge there has been a decline in screening in younger age group and they have engaged the behavioural insight team to test why this is the case. Evidence highlights that 7 out of 10 come forward for screening on average and there is significant work required to improve this. There is a need to understand the barriers to uptake of screening and empower the population in GM to make the choice to attend. JP highlighted the need to align services to meet the needs of the future and reducing variation.

There is a need to implement new screening programmes, for example FIT screening in bowel cancer, which has the potential to increase participation by 7%. JP also highlighted the developments bowel scope roll out by 2020, which is ahead of plan.

There are several challenges to deliver the screening programme including workforce demands, there is a need for considerable collaboration if it to be sustainable and have capacity to meet the needs for the future. The screening programme supports innovation and research done already in GM and the team's ambition is to take this forward to continue to improve the screening programme.

RPre questioned GM uptake of breast screening as this is below national performance. NFar highlighted that the uptake in BME groups is much lower and this needs increased focus, particularly in cervical screening. CK described difficulties in measuring this through Health Equity Audits, but accepts we must review this across the programme to understand barriers to uptake. DW, representing the VCSE Advisory Group, asked about engaging the VCSE community as it has strong links within communities and screening team should engage with the group. JP and DW will discuss outside of the meeting.

RPre felt that too much emphasis was being placed in deprivation as the main factor in the decline in screening uptake as deprivation hasn't increased significantly in the last 5 years. JP acknowledged this and indicated the team would develop a more detailed analysis in early 2018. RPre stated that the GM screening results were the worst in England outside London and this is viewed as unacceptable.

AB highlighted access to screening, given public expectation, e.g. the younger population is more impatient, wanting more open access and is less inclined to wait for appointments. DW discussed that education is vital so there is awareness in the population and we must get young people to engage and encourage parents to support this.

RPre asked for the March 2018 GM Cancer Board to see a clear improvement action plan.

Action: JP to provide an action plan and update on the screening to the GM Cancer Board in March 2018.

6. Personalisation – why it matters: Hilary Garratt

RPre introduced Hilary Garratt, who is the Director of Nursing for NHS England. HG attended to discuss her experience as a cancer patient, the personal impact of this and to introduce the discussion on personalised medicine. HG discussed her experience of being diagnosed with Breast cancer early in 2017. She had (to date) 42 clinical appointments, all of which were felt to be valuable, with two exceptions, as she came to depend on her appointments for support, advice and guidance. She recovered quite quickly following treatment including two surgeries and radiotherapy, completing this in August 2017. She is still recovering from the consequences of ttreatment, both physically and psychologically.

HG described the care/cure balance and the amazing skills of doctors and nurses who cared for her. She felt that importantly that 80% was around good care and 20% was cure. She illustrated the importance of personalised medicine, particularly as she had the second surgery and had her lymph node removed. Due to this HG was not eligible for Oncotype Dx testing in the UK and she chose to pay to have this done in the USA. HG was aware that 30% of patients don't benefit from chemotherapy. In her case the test was positive and she avoided having chemotherapy and the side effects and what would have delayed completion of treatment.

HG discussed the importance of choice, which was really important in her cancer experience and the criticality of the amount of information given, at a right pace that can be absorbed. Time to reflect and the ability to change your decisions regarding treatment if needed were also essential elements. The professionalism of the team helped HG to identify the right question and gave her permission to change her mind.

HG discussed that her family took a team approach, family members attended appointments and were welcomed by the teams. Family members felt the team were there for them in addition to HG. The breast specialist nurse spent over two hours explaining the treatment options. HG experienced post-operative issues with arm movement and the physiotherapist and her personal trainer supported her to get back to normal life and listening to the family as well, which was important.

She stressed how much the environments matter. Waiting rooms face patients with their mortality, whilst the coffee areas and shops can be 'little havens for patients'. She recognised all staff, including the volunteers with 'lived experience'; stressing the value of volunteers and the importance of the environment in which patients wait for treatment. She said she'd felt very fortunate to be able to access the advances in treatment in GM and was in awe of the skills of the teams and how safe this made her feel. She also pointed out the importance of rituals when having cancer treatment, such as ringing the bell at the end of treatment and all the patients and clinical staff clap at this time and everyone is part of it and this can be very supportive.
She also emphasised the currency of time and the meaning this takes on a cancer patients, especially when time may be limited. She stressed the impact of waiting for appointments, waiting in clinic etc. and the associated periods of worry for patients and their families.

In stressing the importance of listening to patient stories RPre thanked HG for sharing her story with the board. He noted the 'care aspect' in this, the whole 'team' focus and the importance of environments in hospitals for patients. RPre reiterated it is vital we review what we can do to improve experience and the care that really matters to patients. DM reflected that HG had a good experience of cancer services in GM, but he felt this isn't the experience of all.

RBrist raised the issue of research and clinical trials, asking HG whether there was an opportunity to discuss clinical trials as part of her care and treatment. HG said she was offered lots of trials

and did participate in one study. She also noted the importance of a discussion with a clinical fellow who gave her information on Oncotype Dx. DW questioned how we could help less well informed and supported patients to have a similarly positive experience. HG said she feels health literacy is critical.

DS summarised eight key points in the discussion:

- Listening to patients is critically important
- The vast majority of appointments attended were valuable
- The critical importance of patient information, very good in this instance but this needs to be consistent across all cancers
- The importance of environments must not be underestimated, given the importance to the patient
- The importance of family being included in all aspects of the patient's diagnosis, care and treatment
- The currency of time and impact of waits and delays
- Personalisation and personalised care, the value of nurses in HG's experience, especially breast specialist nurses.
- This story highlights the importance of personalised medicine and the need for GM increasing its focus on genomics and connecting this to shared decision making

7. Personalised Medicine: Fiona Blackhall, Anne Armstrong & Bill Newman.

FB thanked HG for setting the scene for the presentation on personalised and precision medicine.

Personalised medicine identifies the molecular finger print of the cancer to identify patients who will benefit most from chemotherapy and spare those patients who will not benefit. Oncotype Dx, used in breast cancer, as discussed by HG is one example. There are a number of international guidelines for node negative breast cancers, and oncotype DX is NICE approved for node negative breast cancers, in which a risk score is generated and discussed with the patient. HG's breast cancer was diagnosed at a point in time when evidence is being generated for patients with one node positive and is currently being reviewed through a number of trials in the UK to gather an evidence base. Breast cancer is ahead of the game in personalised medicine currently, but this is expanding into other cancers including lung.

FB explained the importance of 100k Genome project in terms of identifying larger numbers of patients, enabling research teams to identify clearer cancer signatures that can be extrapolated to wider populations and can be used clinically to improve outcomes. This will reduce the number of patients getting treatments and the associated effects that they will not benefit from and improve efficiency.

Precision medicine can be explained by specific molecular changes in the cancer cells which drive cancer cell growth. Precision medicine enables targeted therapies which can switch off the cancer cell and there are a number of examples of these in use for cancers including lung and breast cancer.

A full explanation would be given in the slides set which will be distributed.

FB summarised that the implementation of precision and personalised medicine is being led by GM, as the research laboratories in GM are at the forefront of such testing and research. The teams have joined forces with pharmaceutical companies' horizon scanning for new developments and to ensure key quality standards and quality assurance is maintained throughout. FB said the future of research in cancer lies with tests such as liquid biopsies, in which a blood sample is taken to identify circulating tumour DNA. This is vital to identifying cancer earlier, with less invasive tests and means patients can start treatment sooner. We therefore want to lead this in GM as the vision is for very patient in GM to have access to genetic testing, so we can answer the following questions:

- Which patients will benefit most?
- How do we ensure equity of access to these services for all patients in GM?
- How do we get these tests available, validated and assess the financial implications?
- How do we share best practice?

FB requested the establishment of a 'pathway board' for Genomics to review and monitor progress and ensure the connection of the research to clinical practice.

RBris said that we have world experts in cancer research in GM and we must fully embrace this. A MCRC Director he supports the need for this new board and would want this to include a focus on the workforce and training the next generation of cancer researchers, for example doubling the number of clinical fellows. There are also opportunities to lead on clinical trials due to the largest number of bio-markers lab in the country. GM could lead internationally on this too.

BN, Clinical Geneticist and Genome Project Lead, said there is currently a 'state of flux' regarding the re-designation of laboratories in the UK, in which we will see a reduction in genetics labs in England from 17 to 7. The outcome of this will lead to a directory of tests which will be nationally commissioned and approved, which we have never had before. We will have a more directed set of tests which will be of significant benefits to patients. BN stipulated that there is an opportunity for researchers in GM to do the next set of tests and be at the forefront of future developments.

RPre, noted the general support for the establishment of the suggested Genomics Board.

Action: DS to set up a meeting with key leads to establish the new board and report back to the GM cancer board in March 2018.

8. 62-day report: cancer lead review of systems in GM: Miss Susi Penny

SP was introduced to the board; she is the Pathway Director for the GM Head & Neck Pathway Board and Cancer Lead Clinician at Tameside Hospital. She highlighted the very clear challenges to and increasing difficulty with the sustainable delivery of the 62-day cancer standard in GM and the implications for all our patients. Achievement is only at aggregate level and isn't consistent across populations and tumour groups.

SP stressed that even when Trusts are delivering on the standard, patients still wait weeks for diagnostic results and the start of treatment, with over a 1000 patients falling out of the 62-day standard over the last year, which is unacceptable. There are variations in delivery of the 62-day standard across Trusts in GM, with up to a 20% difference between the best and worst performing.

SP was asked in June 2017 to conduct a clinically led review of 62-day performance and processes supporting this, on behalf of GM Cancer and the Director of Operations group. SP visited every trust in GM providing cancer services, met with cancer services managers, some lead cancer nurses and lead cancer clinicians who were available. She asked a number of questions around what works well in each organisation and what doesn't. From this she has identified a number of recommendations, which will be required to ensure the sustainable achievement of this standard.

SP reviewed reporting structures within trusts, the attendance at trust cancer meetings and how each trust's cancer systems worked. There was an acknowledgement that cancer referrals have gone up by 30%-40% which is putting considerable strain on the system. Pressure on diagnostics is considerable and patients often have to go to a number of provider trusts to access services.

SP said that we need to go back to basics, to review best practice guidance, change practice and scrutiny from GM Cancer is an important part of this moving forward. Her report identifies key actions and recommendations in a report which will be shared in January, as well as individual plans for trusts. It is also important that the pathway boards are held to account for delivery on this, as well as lead cancer clinicians and provider trusts.

RPre stressed importance of delivering on this 62-day standard and we will not have access to treasury funding if this is not delivered.

IC said the ambition of the GM Cancer Plan is delivering world class outcomes and consistently exceeding the 62-day standard. He said the 62-day standard is not world class, in the eyes of patients, this is a soft target and many patients wait beyond 104 days, significantly longer than the standard. IC went to say he had reviewed the publicly available figures and as a board we note the trusts that are consistently not achieving and get an understanding as to why and how this was going to be addressed. IC identified which pathway and organisations are failing and asked for a response from the board.

FN noted some key achievement to the delivery of the 62-day in many organisations and the need to all support the pathways and trusts that are failing. We need to set stretching but achievable standards. JS noted the position of Pennine Acute and the impact of this on GM and stressed this is recognised and is a priority. Pennine is part way through a deep dive of cancer services, review capacity and processes and will be making changes from this.

RPre expressed concern regarding leadership from trust lead cancer clinicians, who have time in job plans to lead the cancer agenda in their organisations. RPre requested DS to convene a meeting with cancer leads, to secure ownership of the clinician's accountability for cancer within their Trusts. FN asked that this is widened to the triumvirate of trust cancer clinical lead, lead cancer nurse and cancer manager in order to develop this. AE stressed making sure patients get into and through the system earlier, as patients being treated in 62-days do not have better outcomes.

Action: DS to set up a meeting with trust cancer clinical leads, lead cancer nurses and cancer managers and Director of Operations group and report back to board in January 2018.

9. Haematological Malignancy Diagnostic Services (HMDS) external review summary: David Shackley

DS briefly explained we have experienced over 10 years of non-compliance for haematological malignancies diagnostic services in GM. Due to this, many providers have been sending samples outside of GM, with a significant percentage going to Leeds HMDS. To address this, an external review was conducted in June 2017 on behalf of GM Cancer and the providers led by a Dr Robin Ireland, an experienced haematologist from Kings London. This review concluded in October 2017.

Dr Ireland carried out extensive reviews of the services in GM, including discussions with providers, commissioner's, key stakeholder and patients. This cumulated in a presentation to the providers of the services in GM, Manchester Foundation Trust (MFT) and Christie Foundation Trust (CFT). This concluded that, to deliver a compliant service in GM, the lead provider will be MFT, with CFT as a key provider. The organisations will work together on an implementation plan over the next 18 months. The recommendations were presented at the Provider Federation Board (PFB) in November 2017. AB, Chair of PFB, confirmed unanimous support in this recommendation and stated the presentation of the findings by Dr Ireland was excellent. Dr Ireland will be producing a final report summarising findings and recommendations.

Action: Dr Ireland's final report to be brought back to GM cancer board in January 2018 for final approval.

10. Greater Manchester Cancer: Vanguard Innovation update: Jenny Scott

JS said that the Vanguard is now in its final 6 months and there will be a comprehensive evaluation and recommendations to the GM Cancer Board regarding the projects. JS described developments and progress of the key projects which are all detailed in the paper.

JS highlighted the 'goals of care initiative', led by Professor Janelle Yorke, that is important to patients around their expectations of treatment and this extensive piece of work with oncologists, is rapidly moving and providing some key outputs and learning. JS also referred to the pilot of patient self-assessment, led by Professor Ken Muir. This will enable individuals to assess their current risk of cancer to support fast tracking via GP to diagnosis. The vanguard team is working with Lloyd's Pharmacy and the cancer champions on this.

Finally, the Vanguard team is working with Macmillan on a project on 7-day palliative care services and has secured circa £1.9m of funding from Macmillan to run two 2 pilots on this. TH was asked to convey thanks to Macmillan for supporting this.

Action: RPre to ensure that Vanguard programme of work is brought to the top of the agenda for the next meeting in January to allow time for discussion.

11. Papers for information were noted

Unable to pick up any questions or comments about these due to time constraints.

12. Closing comments:

Ian Clayton (IC), our new patient representative was welcomed to the board. IC suggested that all papers coming to the Cancer Board should have a section for statements about how the content of the paper benefits patient outcomes, experience and efficiency. IC also expressed concerns about the Vanguard Commissioning Project and progress on this and the resourcing of the Cancer Plan.

Helen Thompson was introduced as the Interim CEO Designate, Stockport FT, replacing Ann Barnes.

Ann Barnes summarised her thoughts summarised her thoughts following her final GM Cancer Board meeting. She emphasised the power within devolution and the importance of seizing this unique opportunity in GM to do things differently. AB noted performance is getting harder to sustain and stressed vigilance given financial constraints, increases in activity etc. She suggested adding 'innovation' into the title of the board. AB was thanked by the board for her support and leadership.

David Makin, also in his last board meeting, shared his final thoughts. DM said he has enjoyed his time on board, describing the board initially as a quite disparate, before it became more organised and focused in recent years. DM expressed disappointment and frustration that in some instances progress has been slow. He acknowledged that the system has moved on but he remains concerned regarding the speed of progress. DM wished the board well but encouraged the board to push for more. The board thanked DM for his support and determination to do the right thing on behalf of cancer patients in GM.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Paper number 2

Greater Manchester Cancer Board

Action log

Prepared for the 12th Jan 2018 meeting of the board

	ACTION	AGREED ON	STATUS
1	Review of Greater Manchester's SACT strategy to be conducted, co-producing a refined strategy. To return to board with update Nov 2017. AW to lead.	19th May 2017	SACT Strategy to be circulated to relevant groups update **February board 2018**
2	HMDS review: outcome of external review and recommendation	21st July 2017	External review team to update GM cancer **January 2018**
3	Recovery package: paper on update of progress in implementation to report back cancer board in January	21st July 2017	Paper for GM cancer board **May 2018**
4	MDT reform: DS to report back to GM cancer board in January on progress on pilots	21st July 2017	Paper for GM cancer board **March 2018**
5	JP to provide an action plan and update on the screening to the GM Cancer board in March 2018.	3rd November 2017	Paper GM board **March 2018**
6	DS to set up a meeting with to develop the new Genomics Board and report back to the GM cancer board in March 2018.	3rd November 2017	Paper GM board **March 2018**
7	DS to set up a meeting with cancer clinical leads, lead cancer nurse and cancer managers and Director of Operations team and report back to board in January 2018.	3rd November 2017	Paper for GM cancer board **January 2018**
8	RPre to ensure that Vanguard programme of work is brought to the top of the agenda for the next meeting in January to allow for time for discussion.	3rd November 2017	Added at highlight agenda item to board **January 2018**

Paper number 3

GREATER MANCHESTER CANCER VANGUARD INNOVATION PROGRAMME

PROGRESS UPDATE JANUARY 2018

EXECUTIVE SUMMARY

Workstream	Key highlights
Prevention	• 242 people trained in the spoken word toolkit for bowel cancer screening. 3 stakeholder training sessions held. • Stoptober smoking campaign had specific focus on GM football clubs. 'Don't be the one' chosen for use in New Year stop smoking campaign. • 2050 registered Cancer Champions with access to new digital platform (www.icangm.co.uk) • Randomised Control Trial in breast screening and bowel screening completed. No statistical difference in letters used for breast screening. Bowel screening 'predictiv' RCT recruited 1600 people to test out 3 behaviourally informed letters. 8% increase in participants saying they would do the test. RCT in cervical screening being developed. Teachable moments research around screening undertaken. • Evaluation of Cancer Rehabilitation Exercise Referral Training undertaken. Significant support for using screening events as teachable moments.
Early Diagnosis	• Impact of One Stop MDC at Withington Community Hospital now evaluated. Potential for joint work with ACE2 being discussed. 71 patients seen, 10 were diagnosed with cancer 60% of whom had been referred on an incorrect cancer pathway. 100% patients rated service good or very good. Significant reduction in time from GP referral to diagnosis. • As part of Faster Diagnosis project, Direct to Test colonoscopy for lower GI patients rolled out across Bolton. 10.6 % of patients referred compared with pre pilot rate of 0.5%. Time from referral to diagnosis has been halved. Streamlining lung cancer diagnosis pathway implemented on 11th Sept. 28 patients retained for CT scan following abnormal x ray of which 17 patients had abnormal scan and were referred on. Direct to test for oesophago gastric cancer diagnosis has a low take up from primary care. Work with Bolton GPs progressing. • Pilot for patient self referral algorithm tool has commenced in 1 GP practice and 2 community pharmacists. The tool has 5 cancers for assessing risk. • All 7 pathology providing trusts were involved in digital pathology pilot. 1500 patients cases (2500 slides) captured in 3 month pilot. 35 pathologists involved in reviewing cases. Benefit realisation / evaluation report to be produced in Jan 18.
GP Education	• Over 60% of GP practices in GM have now registered to use Gateway C and

	its use in London is extending. Discussions are underway regarding ongoing funding.
Living with and Beyond Cancer	• Aftercare pathways for colorectal, breast and prostate patients at UHSM/ PAHFT / Trafford / SRFT being piloted using digital tracking (Infoflex). • Goals of care decision tool piloted between Jan – March 2017 (24 palliative care patients). CAN Guide tool to support decision making being piloted (80 patients at Christie, 40 patients in London) • Bid submitted to Macmillan to secure circa £2 mill resources for specialist palliative care pilot across GM has been successful. A proposed commissioning framework for delivery of standardised approach to 7 day SPC is now also under review and will form the recommended model for all localities to follow in 2018-20.
Cancer Intelligence	• IWantGreatCare patient feedback tool being piloted at 5 sites with 3 further sites under discussion.
Pharma Challenge	• Evaluation reports on the projects will be prepared in January 2018
Commissioning Reform and Testing of Accountable Cancer Network	• Consideration on how commissioning element of GM Cancer can become embedded as a central component of the GM Commissioning Hub whilst sustaining and enhancing the integration within the wider GM Cancer team. A proposal has been submitted to Directors of Commissioning Group
Evaluation	• Cycle 2 of national Cancer Vanguard evaluation completed. Local health economic evaluation with University of Manchester progressing.
Legacy	• Second meeting of national Communities of Practice Group planned for 8th Feb 2018 in London. Clinically focussed on achieving national consensus on 4 timed pathways.

Visit our website at: http://www.gmcancervanguardinnovation.org

GREATER MANCHESTER CANCER VANGUARD INNOVATION PROGRAMME

PROGRESS UPDATE DECEMBER 2017

Work stream	Summary Progress
Involvement of People Affected by Cancer (PAbC)	During November and December, service user representatives have: • Met with a senior pathologist involved in the Digital Pathology pilot to find out how the digital processing of tissue samples can improve accuracy of diagnosis. Being informed in this way will ensure that inclusion of a person affected by cancer in a promotional film at the end of the pilot is accurate and true. • Attended training alongside staff at Pennine FT who are implementing *IWantGreatCare* so that they are informed of the patient's perspective and are able understand how to promote its completion to current patients and their families. • The User Involvement Steering Group heard from Dr Wendy Makin about the achievements of the Aftercare work stream presentation and two service user representatives continue to work with the project team on co-producing the aftercare event for January 2018. • As members of the Steering and Oversight groups, critiqued the project evaluation reports for Gateway C and Medicines Optimisation (IMFQuintiles project) • Attended the HSJ awards evening as part of the Gateway C team nomination. • Been testing the CAN-Guide remotely and provided feedback on the ease of use and relevance of the site via survey monkey.
Prevention	**<u>Project 1: Social Marketing and Behavioural Change</u>** • 102 (242 in total) individuals have been trained this quarter on utilising the bowel spoken word toolkit. Included in this figure have been 3 stakeholder training sessions with staff and volunteers working with our BAME populations, library staff and social care staff, as well as staff from the Prison service. • Stoptober was amplified across GM. This included a GM specific radio advert aimed at football fans and the promotion of the campaign through digital/social media channels. We are awaiting the formal evaluation/ impact data. Commissioning for the New Year mass media smoking quits campaign, Don't Be the One, has commenced in conjunction with the GM Tobacco Control team.

Project 2: Citizen Led Social Movement

- The Cancer Champion social movement continues to grow and gain momentum with over 2050 registered cancer champions. To support awareness raising and promotion of the movement small grants funding has been made available for groups/organisations to deliver a diverse range of innovative events in January. The events will be bespoke to individual communities and aimed at supporting one of the 7 calls to action identified as priority areas of focus.

Project 3: Enhanced Screening

- The Breast cancer screening RCT and Bowel cancer screening online RCT have completed. The Breast RCT reported no statistically significant difference in breast screening appointment attendance between patients who received the usual invitation letter and patients who received one of the simplified letters containing behaviourally informed messaging. Additional learning opportunities are being explored. The bowel online RCT, 'Predictiv', recruited 1,600 individuals aged 55 years+ and tested three behaviourally informed letters alongside the control. Participants were asked a series of questions capturing their intentions to use the home test kit. The most effective and statistically significant message was that of the 'certainty effect', removing uncertainty about cancer, which resulted in 8.6% more people saying they intended to complete their screening compared to the standard letter. Additionally the letter which tested 'anticipated regret', a message which highlights the opportunity to avoid regret in case cancer is detected at a later stage in the future. Although not statistically significant, this resulted in an 8% increase in the number of participants saying they would complete the test. This 'anticipated regret' message also tested well when participants were asked about recommendations to family and friends and support for the programme and therefore the report recommended using the 'anticipated regret' message in any new bowel cancer communications

- Cervical cancer screening RCT was not authorised by PHE Research Advisory Committee, therefore GMHSCP are currently looking at alternative options to test behavioural insight theory with cervical cancer screening letters.

- Qualitative insight research into the uptake of breast and cervical cancer screening programmes has commenced. This will produce 'actionable insights' into why specific groups across GM to not take up cancer screening opportunities, particularly women with learning disabilities, those from low socio-economic backgrounds and BAME women who are all identified as

	least likely to attend for screening. **Project 4: Lifestyle based secondary prevention** • Qualitative insight research into the opportunity to delivery teachable moments during cancer screening has completed. The findings strongly indicated that screening providers and service users would welcome a teachable moment before or during a cancer screen. In particular, service users would welcome information about other screening opportunities and weight management and would prefer information given to them in person at the appointment.
Early diagnostics	**Project 6: Query Cancer one stop clinics (MDC)** • The data collected from the MDC pilot at Withington Community Hospital (UHSM) has now been analysed • The clinics saw a total of 71 patients and there were 10 of these patients which were found to have a diagnosis of cancer of which 60% were referred in on the wrong pathway • 80% of those that did have a positive cancer diagnosis were told on the day • 100% of patients rated the experience either Good or Very good • The data has shown a significantly reduced average time to final diagnostic (23 days to 9 days) and subsequent definitive diagnosis (35 days to 19 days). • Further work will need to be done in order to assess the sustainability of the model and the optimal referral route for all patients currently referred in on a 2WW – which will mean combined learning from ACE2 and Find out Faster **Project 7: Faster Diagnosis** **Lower GI** The direct to test (DTT) colonoscopy pathway for lower GI patients has now been fully rolled out across Bolton. 10.6% of suspected lower GI cancer patients have been referred direct to test since commencing the pilot in April compared to 0.5% prior to the pilot. Whilst the number of referrals into the DTT service continue to grow, uptake is still sub-optimum. Work continues with primary care to encourage appropriate and quality referrals from GPs. As part of this work, Bolton FT are currently auditing referral pathways by practice. Practices not using the STT pathways will then be contacted directly by the CCG team for feedback as to why the STT pathway has not been used. Initial data is very promising, demonstrating a reduction in average time from referral to colonoscopy from 18.6 days to 9.5 days for those being referred DTT. Time from referral to diagnosis is demonstrating an average wait of 13.7 days for

DTT patients against 27 days for those on the traditional pathway. The project team also monitor the pathway beyond diagnosis to ensure the benefits of faster diagnosis are echoed throughout the pathway. Whilst the numbers of patients from DTT with a positive diagnosis of cancer are small, initial data is showing efficient treatment time of these patients well within the 62 day target. The project team are continuing to refine and expand audit methods in this area.

Lung

The pathway for streamlining lung diagnosis (X ray / CT / PET) was implemented on 11th September. This involves the hospital retaining any patients with a chest x ray indicative of cancer for further chest investigations, rather than sending them back to the GP for a CT referral. This will reduce the time between chest investigations and minimise unnecessary appointments. 28 patients since 11th September have been retained for CT scan following abnormal x-ray suspicious of cancer, and of those 28, 17 then had an abnormal CT scan and were referred on to Thoracic for further investigations/clinic appointment. Work is ongoing to ensure that patients are always informed by their GP that they may be phoned with an appointment for a CT following their x-ray, and to understand whether utilisation can be further improved.

Upper GI

The project team continues to promote direct to test OGD and the expedited jaundice pathway for suspected upper GI cancer, however low uptake from primary care remains an area of concern. Bolton CCG are supporting the Trust to engage with GPs and understand reasons for this and the best engagement methods. As part of this work, Bolton FT are currently auditing referral pathways by practice. Practices not using the STT pathways will then be contacted directly by the CCG team for feedback as to why the STT pathway has not been used. BFT consultants are also actively triaging some of the 2ww referrals and redirecting STT where appropriate.

Other

The Faster Diagnosis project team are in the process of feeding back to the national evaluation team on the project so far. Interviews have been completed with commissioners, with further discussions to follow with operational and clinical leads.

Project 16: REACT - Patient Self-Referral

- Four different focus groups have now taken place in the co-development of a web based tool to aid in patient self-referral.

	• The tool incorporates five cancers (lung, colorectal, breast, prostate and ovarian) and an all cancer algorithm to determine the participants current risk of cancer based on the symptoms inputted. • Celisio have signed an SLA to pilot the tool in two pharmacies and help develop the pathway for a patient that has symptoms that require further investigation. This pilot commenced on the 11th of December and will run for 8 weeks • There will be further focus groups to aid with the development of the downstream processes involved in referring a patient for those investigations. • There is also ongoing engagement with a number of GP practices across GM about the potential to pilot the tool in GP waiting areas. **Project 17: Digital Pathology** • 7 Pathology provider sites participating of which all 5 scanning sites have now completed their case / slide scanning activities. In total, 1500 Patient Cases with 2500+ slide images have been captured on the Sectra cloud based service in 3 months. • 35+ Pathologists have reviewed and completed cases. • Cellular Digital Pathology service decommissioning plan invoked. • Feedback gathering / Lessons learnt workshop to take place on Wednesday 13th December. • Project Video commissioned, filming of different stakeholders (Pathologists / BMS's etc.) continuing. • End of project report / benefit realisation metrics collation activities initiated. Targeted for delivery end of Jan 2018. • All project milestones on track.
Cancer Education (Gateway-C)	**Project 5: GP Cancer Education** Full evaluation report with recommendations was approved by Cancer Vanguard Oversight Group on 6 November. The Christie, Associate Director of Education is now seeking a decision from Cancer Board to fund the Cancer Education Strategy and future sustainability of Gateway-C. In the meantime the project team continues to market the platform to GPs in Greater Manchester & Eastern Cheshire, to ensure users continue to complete modules, is testing applicability with community pharmacists and is also in discussion with other potential partners nationally.

Timed Pathways	**Prostate Timed Pathway (Led by GM)** Project group met in September with full representation from patients, commissioners, GPs, diagnostics and surgery. Agreed the surgical pathway and the principles of aftercare and follow-up. The team is now working on estimating the MR capacity that may be required to deliver the new pathway. Agreed to meet once more in December to finalise the work. The three other pathways included within this project are Lung, Colorectal and Oesophageal. The next Communities of Practice event (the collaboration between the Cancer Vanguard and the 16 Cancer Alliances) will take place on 8th February 2018, focussed on achieving national consensus in these 4 timed pathways (see attached draft agenda). This will be a clinically led discussion and will aim to prepare pathways to support compliance with key national targets such as 62 days. A second phase focus will be on the aftercare pathways to enhance patient experience.
Living with and beyond cancer	**Project 9: Aftercare Pathways** The new colorectal stratified pathway of aftercare, supported by the Recovery Package and a digital patient tracking solution (Infoflex), was approved by Manchester NHS Foundation Trust South (MFT South) IT Governance and clinical teams and went live in mid-October 2017 and is currently under evaluation. This will track 40-50 patients deemed suitable for self-management in the first year. The same initiative is planned for both MFT and Pennine Acute Hospitals Trust (PAHT) for the breast pathway by the end of February 17. This project supports patients to self-manage and supports and extends upon the existing award-winning Macmillan Cancer Improvement Partnership (MCIP) breast aftercare pilots. New high level models of stratified prostate aftercare for surgical and radiotherapy patients were agreed by the Greater Manchester (GM) Cancer Urology Pathway Board in May 17 as the approved GM model. A pilot of elements of this aftercare pathway – reducing the number of patient outpatient appointments and testing a new model of stratification - started in Trafford at the beginning of November, in partnership with primary care and a local community clinic. This is currently under evaluation. **Project 10: Enhanced Patient Decision Making** A shared decision making tool based on the Goals of Care Initiative piloted with 24 patients currently receiving chemotherapy with palliative intent across 3

	Christie clinics (HPB, Lung and Colorectal) from Jan-Mar 2017. An enhanced patient decision-making package - CAN-GUIDE (Cancer Goal Use In Decisions) - is now complete and the pilot began in October with a further 50 patients across 4 clinics at The Christie and a further 10-15 patients in 1-2 clinics across UCL/RM Partners. This project supports patients to identify and document the aims of their treatment and personal goals and evaluation will take place in January 2018. **Project 11: Specialist Palliative Care** A gap analysis of the findings from the pan-vanguard 7 day specialist palliative care service mapping was completed, updated and signed off from 12 localities. Results was formalised through the December Task and Finish Group meeting on the 12th of December. From this key learning, a proposed commissioning framework for delivery of standardised approach to 7 day SPC is now also under review and will form the recommended model for all localities to follow in 2018-20. The data collection and the gap analysis aided in discussions with Macmillan regarding funding for a potential pilot to start in April 2018; of which now two Innovative early adoption sites with were approved for an 18 month pilot in Wigan and Salford. The evaluation document is currently under consultation for project close and sharing of best practice.
Cancer Intelligence Service	**Project 14: Cancer Intelligence Service** Performance and outcomes metrics are now being reported monthly in a basic dashboard format. Narrated reports are being produced bi-monthly. Additional pathway specific performance analyses have been completed for Lung, Gynae, HPB. Scenario analyses have been undertaken to show how reducing 2WW and time to decision to treat can reduce overall 62 day waits for all cancer types. Analysis of 62 day breach allocation using proposed 38 day inter provider transfer deadlines have been produced for internal review. • Request for GMEC outcomes data from PHE has now been approved and data received. Two new statisticians have been recruited and first analyses are expected to be completed early January. • The build of our Cloud dashboard environment is now complete and the dashboard build is under way. Performance metrics will be reported via this interactive dashboard from February.

	• DARS application for the sharing of provider data has been through pre iGARD. Request for the publication of GM Cancer Vanguard FPN has been met and the DARS application is due to go to iGARD before end of December. • Patient experience reporting via iWGC is now being trialed across GM&EC at 5 sites. There is additional interest in participating in the pilot from 3 new sites.
Medicines Optimisation (MO)	**Project 15: Medicines Optimisation** Biosimilars education materials will now be used by breast pathway teams in advance of the roll-out of trastuzumab. Good media coverage around Amgen (denosumab) project. Whilst this project was led by UCLH the model created is freely available for all Trusts across the country to use and is accessible via the cancer vanguard website. https://www.newstatesman.com/sites/default/files/ns_healthcare_supplement_nov_2017.pdf Evaluation reports from the two Christie led projects QIMS and Celgene will be submitted to the vanguard oversight group in January 2018.
Commissioning reform and testing an Accountable Cancer Network (ACN)	**Projects 12 and 13: Reforming the Commissioning Landscape and Effective Use of Cancer Budgets** • To ensure the successful delivery of the GM commissioning review, a working group has been established, consisting of colleagues from CCGs, Local Authorities, the Provider Federation Board and the Partnership Team. A delivery plan is in development and the following objectives are of particular relevance to cancer services: o Developing and implementation of governance arrangements, which are legally compliant and support the delivery of the local and GM level ambition. This strand of work, including the formal establishment of the Joint Commissioning Board as a joint committee, will represent an early priority. o Agreement of the detailed breakdown of the services to be covered across the common standards, strategic support and GM level commissioning categories. This includes the scoping and phasing of services to be placed within a Commissioning Hub for GM level commissioning. • As such, a proposal has been submitted to Directors of Commissioning (DoCs) regarding the responsibilities of the GM Commissioning Hub in

	relation to cancer services. DoCs are asked to support the proposals going forward to Chief Finance Officers and the Association Governance Group (AGG) of Greater Manchester CCGs. Cancer related examples identified as to where we can apply the principles agreed as part of the GM payment mechanism review to the practice of costing and paying for cancer services.
Communications and engagement	GM Cancer Vanguard was represented at the Britain Against Cancer conference held on 5th December 2017 in central London along with London Cancer Vanguard colleagues. This is the largest event of its kind in the UK and marked the launch of the All Party Parliamentary Group on Cancer's report into the progress of the national cancer strategy. Cancer Vanguard innovation website has been updated with items about the launch of the Can-GUIDE website to support patients with progressing illness and a case study of a cancer champion. In the last 30 days our website http://www.gmcancervanguardinnovation.org has had 2,400 views and attracted 400 users Our Twitter following stands at 1,200
National Programme Evaluation	Optimity Technopolis have now moved onto completing Rapid Cycle 2 of the national vanguard evaluation programme and a feedback meeting was held on 12th December. The evaluator will continue to work with the Vanguard partners beyond March 2018 to determine the longer term impact of the Vanguard on clinical outcomes and patient experience. The Qtr. 3 and 4 meetings with the New Care Models team will be combined, presenting the opportunity to summarise the core elements of work and deliverables during the two year Vanguard programme. The sustainability of this innovation approach will be considered at both a local GM and national level. The second Communities of Practice event has been organised for Thursday 8th February 2018 in London. This will be clinically focussed on reaching national consensus in timed pathways. (see attached draft agenda)

Greater Manchester Cancer Board

Paper number 4

Date: 12 January 2018

Title: GM Lung Health Check Programme Update

From: Dr Gunjit Bandesha on behalf of Dr Richard Preece and Jane Pilkington

Purpose of paper

This paper outlines the work of the Greater Manchester Health and Social Care Partnership (GMHSCP) to develop a series of investible propositions to enable the roll-out of a targeted lung health check programme across Greater Manchester (GM).

The City of Manchester MCIP Pilot (2016) demonstrated the impact of a targeted lung health check programme supported by low dose CT scan to identify lung cancer at an earlier stage. There was a significant stage shift with 80% of those detected having early stages one and two disease. This resulted in 64% of patients receiving surgery with intent to cure as opposed to 16% of patients who would receive surgery in the normal symptomatic treatment pathway. The Pilot also identified other respiratory and cardiovascular disease in the population that attended, with potential to further improve population health and increase the cost effectiveness of the programme. The successful targeting of the highest risk and most deprived cohort in the Pilot demonstrated significant opportunity to reduce mortality and improve health inequalities.

Work is being led by the GM Lung Health Check Steering Board under the chairmanship of Dr Richard Preece. The work so far has been reviewing the international evidence and the local Pilot to assess the feasibility of implementing a GM Population Lung Health Check Programme since April 2017. The results, activity and costs of the Pilot and the North Manchester Lung Health Check Business Case have been used along with best local data and evidence to model the 'at risk' GM population, predict activity and estimate costs for a GM programme. Work is underway to identify the options for the roll out of a lung check pathway for GM, which is embedded in local services.

Modelling work looking at the GM eligible population to date shows that an uptake of 30% in the target population (as in the Pilot), would require availability of 85,000 lung health checks, 28,000 CT scans and lead to a diagnosis of an extra 1,277 lung cancers, of which 812 could receive intent to cure surgery. This would be for the first round of the programme. Figures are also being calculated for each locality in GM and options considered for a phased roll out. Work is also underway to develop financial models using the Pilot costs, national and local data and the best available evidence for a scaled up programme.

There are a number of issues which affect how the programme is developed and implemented including:

1. **Public and professional engagement**

- Public engagement and raised awareness to reach the high risk population
- Predicted uptake rate
- GP engagement and workload – e.g. to co-manage the additional identified morbidity which significantly improves the cost effectiveness of the programme

2. **Pathway factors**

- Risk threshold for CT scan
- Radiological capacity and solutions to deliver, assess and quality assure the CT scans
- Specialised services to deal with increased need for lung resections, radiotherapy and chemotherapy
- Robust smoking cessation services
- Protocols for managing identified morbidity
- Duration and long term sustainability of the programme

3. **System engagement**

- Resource and workforce implications
- Alignment with other transformation programmes
- Support from industry and technology partners
- Research and evaluation

The Steering Group will be considering all of the above to develop solutions which are high quality, feasible and sustainable. Ongoing research and evaluation will be vital to ensure the work continues to drive improvements in service and delivery both in the UK and internationally.

Recommendations

The Greater Manchester Cancer Board is asked to note and support the work to date.
Further briefings will be provided at regular intervals on progress and plans. The next update to the Cancer Board will be February 2018.

Contact

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Paper number

5

Greater Manchester **Cancer**

Summary report of Trust Cancer leads meeting held on 8th January 2018

Date: 9th January 2018

Author: James Leighton

Presented by: David Shackley

Summary

This meeting was called to examine the GM clinically led review of the operational and clinical management processes that support delivery of the Cancer Standards. The objective of the meeting was to agree common processes and Trust level actions to minimise cancer diagnostic and treatment waiting times for all patients on all pathways

This report outlines the agreed outcomes and actions arising from the meeting.

Please note that where the abbreviation of GM is used this is intended to include the East & Mid-Cheshire areas and providers.

Purpose of the meeting

During quarter 3 of 2017/18 the Pathway Director of the Head & Neck Pathway Board, Ms Susi Penney, on behalf of GM Cancer, undertook a review of how Trusts managed the Cancer Standards within their organisations. She visited each provider and met with a range of staff within each Trust, but specifically with the Trust Cancer lead, the lead Cancer Nurse and the Cancer manager.

As a result of this review a report was produced that identified a number of recommendations that would help to achieve greater standardisation of the management processes that support the cancer standards between providers.

Meeting format and attendance

The meeting was held at SRFT and was chaired by Mr David Shackley and all provider organisations were invited to attend. They were encouraged to send a delegation of clinical and nursing leads as well as operational management. All providers were in attendance, with the exception of Salford Royal FT. (The delegate attendance list in appendix A).

Each delegation was paired with an organisationally or geographically linked Trust and would be asked to identify and report on their good practice, were they had issues in managing the standards and then to agree an action plan for the next six months based on this review.

Prior to the meeting each attending delegate was asked to score the recommendations contained within the review report and the results of this scoring would help the meeting identify the priorities and actions to be agreed.

The meeting was supported by the GM Cancer Pathway Board team and invitations were extended to local and specialised commissioning leads as well as NHS England.

Meeting agenda

Mr Shackley welcomed all and thanked everyone for their participation. He provided some context to delivery of the cancer standards across GM. He explained that whilst GM as a system was achieving delivery of the 62-day cancer standard, this masked the fact that there was variation of achievement between providers, CCGs and pathways across GM.

There was input from Ian Clayton, service user representative and GM Cancer Board member on the patient's perspective of how the cancer standards affected their experience.

Fiona Noden, in her role as chair of the GM Cancer Director of Operations group spoke to explain the Cancer access policy and how this would support and inform the work of the providers.

Lastly Ms Susi Penney spoke to her report and explained how she undertook the review. She went on to explain the type of variations in practice that existed and her observations on the consequences of this variation.

Following this and a discussion, the delegations worked at their tables to agree an action plan to take forward over the next six months. The GM cancer team reviewed the system objectives and issues and also agreed an action plan.

Report recommendations identified as key priorities

Those that responded to the questionnaire identified the following actions as the most actively encouraged from each section – **However, further actions were agreed and a detailed final report will be available by the end of January 2018**.

- That Cancer Service Managers are included in all clinical pathway revision projects / work

- There is open sharing of data within the system on diagnostic and treatment times, including diagnostic waiting and reporting times
- An effective radiology diagnostic network across GM is created to maximise the use of resources
- Where one stop and straight-to-test options are appropriate, these should be adopted
- That clinicians managing cancer services within organisations should be supported by a robust decision making and governance structure

Actions agreed by Trust delegations

Pennine Hospitals NHS Trust

- Increase the use of straight to test pathways and one stop clinics across all pathways
- Increase the clinical input into Patient tracking lists (PTL) meetings across the Trust
- Standardise the MDT processes (Pre-meet, PTL meetings & pathways between MDTs)

Royal Bolton NHS FT

- Mandate attendance at Trust Cancer Board meetings
- Mandate attendance at GM Cancer Pathway Board meetings

Wrightington, Wigan and Leigh NHS FT

- Work with business intelligence unit to create a dashboard for cancer
- Undertake a review of all opportunities for straight to test pathways
- Set a stretch target seeing patients within 7 days

Manchester University NHS FT

- Set a stretch target seeing patients within 7 days
- Agree that the Cancer Lead Clinician should attend all PTL meetings
- TMO meeting on both sites of the Trust

Tameside General NHS FT

- Set a stretch target seeing patients within 7 days
- Re-design the Trust Cancer Board to allow the Pathway Board representatives to feedback on work of the Board
- Increase the use of straight to test pathways and one stop clinics across all pathways

Stockport NHS FT

- Set a stretch target seeing patients within 7 days
- Increase the clinical input into Patient tracking lists (PTL) meetings across the Trust
- Review the cancer Board processes and executive support

East Cheshire NHS FT

- Set a stretch target seeing patients within 7 days
- Increase the clinical input into Patient tracking lists (PTL) meetings across the Trust
- Establish a dashboard for turnaround times (e.g. Radiology reporting)

Mid-Cheshire NHS FT

- Work to create a dashboard for cancer
- Review and improve the transition pathways
- Review and improve the cross speciality pathways

The Christie NHS FT

- Set a stretch target seeing patients within 7 days
- Explore how to provide rapid access referrals
- Review of management of PTLs and PTL meetings
- Explore obtaining patient consent at the local Trust before being seen at the Christie

Salford Royal NHS FT

- Do focussed work on setting a 7 day target of 80% of referrals by April 2018
- Develop further a cancer dashboard to improve access to data that can drive change. This will be open access within the organisation to support all staff
- Investigate and set targets to improve diagnostic waiting times (to test & report) for all diagnostic tests and examinations

Actions agreed by GM Cancer

- To send out a summary report of the Trust leads meeting to all participants, within two weeks and provide an update to the Cancer Board and Director of Operations meeting on Friday 12th January. A final report will be published by the end of January 2018.
- Charge every Pathway Board with providing clear timed guidance on all pathways by the end of April 2018
- Look to establish a plan for a Radiology network within the next 6 months, working with the appropriate GMHSC Partnership teams, to support the Trusts and pathways in maximise the use of resources
- Within the next 4 months, GM Cancer will agree a framework for the governance and assurance of cancer standard management within organisations
- That Cancer Service Managers would be included in all clinical pathway revision projects
- GM cancer Core diagnostic and treatment standards (discussed in the meeting) would be developed further and consulted on with proposals circulated by the end of April 2018.

The meeting was closed by Mr Shackley, Ms Susi Penney and Ian Clayton and all agreed to meet within three months to review progress and continue planning ac

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number 6

Greater Manchester Cancer

REPORT to Greater Manchester Cancer:

Review of Integrated Diagnostic Services for Haematological Malignancies in Greater Manchester

1. Introduction

The Greater Manchester (GM) Cancer Plan of 2017 stipulated that 'an ambitious new Integrated Haematological Malignancy Diagnostic (HMD) Service must be set up and in place by July 2018'. This was to ensure compliance to national standards and to ensure patients in GM would benefit from this new service, enabling improved patient experience and outcomes for haematological cancers in GM. GM diagnostic services for patients with haematological cancers are non-compliant with the NICE Improving Outcomes Guidance (IOG) guidance as described in 2003, clarified in 2013 and revised in 2016.

Within Greater Manchester there are a number of diagnostic services that provide effective, high quality contributions to the diagnosis and management of patients who may have Haematological malignancies. However, these services operate in a fragmented, inconsistent and uncoordinated manner, and as a health system GM is still not compliant with IOG on diagnosis in Haematological Oncology. Within GM, the key specialist services for the diagnosis of Haematological malignancies are provided by Christie NHS FT (CFT) and Manchester Foundation Trust (MFT). The provision of specialist services in two separate Trusts has been the principal reason why it has not been possible to achieve a more effective, integrated service in the past.

As a result, the GM Cancer Board, through the offices of the Medical Director, Dave Shackley, instigated an external review in May 2017 to ensure that in the future, patients will have access to reliable, accurate and timely integrated HMDS facilities in GM.

This review has been conducted in the setting of recent changes in the Manchester region; devolution of health and social welfare budgets, creation of the Manchester Cancer Vanguard, re-designation of AHSC status and the 'Single Hospital' and Pathology reviews. In addition, Central Manchester University Hospitals NHS FT, (CMFT) and University Hospital South Manchester FT (UHSM) merged into a single organisation, Manchester University NHS Foundation Trust (MFT) during this review process.

2. Rationale for the review

This review was set up in the context of very clearly defined terms of Reference [Appendix 1] set out by GM Cancer, with the aim to develop a new model for HMD services in GM.

The new model of HMD service in GM should not only provide timely, safe, effective and high quality services but also lead to service improvement, improved patient outcomes and experience and enhanced teaching, training and research activities of the region. The new HMD services must provide diagnostic provision for adults (over 24 years), young people (16 to 24 years) and children (<16 years). This is to be defined through a well-structured leadership model. The most effective way to provide a new high quality service for the diagnosis of haematological malignancies in GM, would be through a partnership that builds on the strengths of all of these team and organisations within GM through collaborative working.

3. Clinical Context

The first national 'Guidance on Cancer Services: Improving Outcomes in Haematological Cancers. The Manual: National Institute for Clinical Excellence', was published in 2003[(1)]. Further clarification for commissioners was issued in 2013[(2)] and a further revision of guidance published in 2016[(3)]. Briefly this emphasised:

- Haematological malignancies are complex:
- Treatments are often very disease specific.
- That ***"improving the consistency and accuracy of diagnosis is probably the single most important aspect of improving outcomes in haematological cancers".***
- This is most likely to be achieved if the component parts of the specialist integrated haematological malignancy diagnostic services (SIHMDS) are located at a single site.

Haematological malignancies are the fifth most common cancer in the UK. The WHO Classification of Tumours of Haematopoietic and Lymphoid Tumours 2008[(4)] and the 2017 revision[(5)] confirm the increasing complexity with approximately 180 tumour subtypes in 15 major diagnostic groups.

Molecular tests are of increasing importance with over 30 additional mutations of diagnostic, prognostic, therapeutic or monitoring importance listed in the latest 2017 WHO revision[(5)]. This trend will continue.

4. Objectives of the Review

The single objective of this clinically led review was to advise the Medical Director of Greater Manchester Cancer on the fastest and most effective approach to ensuring that GM establishes a comprehensive, high-quality and affordable Specialist Integrated HMD Service (SIHMDS) in GM. In order to optimise the care of patients with actual or suspected haematological malignancies.

The broad principles of partnership for a GM solution were agreed as being:

- Patient-centred.
- NICE guideline compliant.
- Supported by the GM Haematological Oncology Pathway Board.
- An operational, IOG-compliant SIHMDS service by Jan 2018 (Timescales subsequently changed to July 2018).

In delivering this objective, the Review should consider:

- Compliance with NICE Improving Outcomes Guidance (IOG).

- The requirements of relevant clinical service users in GM including:
    - support to local clinicians/MDT's,
    - service quality and value for money,
    - turnaround times.
- The best use of existing clinicians, clinical teams, equipment and facilities in GM.
- Future development of the service, including the timely deployment of future innovations in the diagnosis of haematological malignancies.
- The opportunities for clinical, scientific and technical staff to develop their skills and knowledge and progress their careers.
- The development of relevant diagnostic research, innovation and support for research and teaching in GM.
- The clinical leadership and governance required to underpin the effective operation of a GM HMD service.

5. Methodology

In order to maintain a degree of rigor to the process, the review was conducted through several stages, with a 6 months completion timeline:

- ***Pre-Review Phase:*** Senior GM Cancer team provided the independent reviewer with an itinerary and briefing pack containing relevant information and key data.

- **Pre-Visit Preparation**: Initial discussions with both providers and requests for further information from other District General stakeholders, an analysis of relevant data, and identification of the areas for detailed review during the visit week.

- **Review Visit:** The expert reviewer visited Greater Manchester to
    1. Interview key individuals and stakeholders.
    2. Observe practice
    3. Verify information already obtained
    4. Gather further information and propose potential models for a Greater Manchester HMD service.

- **Final Summary Report:** With the information gained from the review process above, the reviewer presented a preliminary report on the findings at the end of the final review visit.

Following this the penultimate draft report was sent to the provider Trusts for comments on factual accuracy, finalised and submitted to the Medical Director, of Greater Manchester Cancer. This will then be submitted to the GM Cancer Board in January 2018.

Activity	**Date (2017-18)**
Reviewers approached	27th February 2017
Reviewers proposals for time and costs agreed	17th March 2017
Reviewer agreed/ HMDS lead	27th March 2017
Pathway Director Sign off and agreement	20th June 2017

a. Review of joint service proposals from CFT and MFT. b. Pre planning visit: Initial meeting with key stakeholders from all 4 MDT groups (NW, NE (Pennine), Central and South), GM Cancer, commissioners and MFT and CFT representatives. c. Follow-up conference calls with representatives unable to attend the stakeholder day. d. Review of additional information provided by GM Cancer, MFT and CFT including previous Cancer Peer Review reports. e.	28th July 2017 25th September - 3rd October 2017
Site visits & initial summary report from the Review Team comprising haematologists from all 4 MDT groups, a patient representative and commissioning representative. Preliminary conclusions and feedback from Review Panel.	5th October 2017 6th October 2017
Preliminary findings presented to Provider Federation Board. Summary paper and ratification at the GM Cancer Board.	20th October 2017 3rd November 2017
Establishment of a partnership board to deliver the HMDS service in GM with ToR and clear framework of delivery.	January 2018
Final report to be ratified at GM cancer board.	12th January 2018

A. Review of joint service proposals from CFT and MFT

Both CFT and MFT were asked to provide a vision document to the review team [Service Description-Vision Documents 1-4]. Both organisations were very supportive of this approach, which allowed them to demonstrate clear vision of how they would develop a compliant HMD service in the future in collaboration with organisations across GM.

B. Assessment from site visits

The Review Group included haematologists, a commissioner and a patient. Both sites (CFT and MFT) were visited on 5th October 2017 and were given the opportunity to present relevant information about their diagnostic services and future development and how they would plan a collaborative service for GM. The review included a tour of the laboratories. The information from both site visits was discussed and collated. [Summarised in Appendix 7].

C. Follow-up conference calls

Clinical teams and management teams from both organisations had the opportunity to discuss current issues and demands on their services during a conference call with the reviewer and GM cancer senior team. These calls were documented and collated for later reference.

D. Review of relevant information

The GM cancer team requested subsequent data and information from both organisations including final vision documents, to help inform the final days of the review process on the 5th and 6th of October.

6. Review Findings

Throughout the review process there was clear engagement and support from all clinical haematology teams across GM, with the ultimate aim to develop a compliant HMD service in GM. Both MFT and CFT have acknowledged the very clear issues in GM, were fully supportive of the review process and showed a real commitment to improving services for haematology patients in GM by taking key roles in this review process.

Evidence gathered through the review process of current HMD service provision demonstrated a very clear 'case for change'.

This report details the case for change and then specific feedback on what the review group found through the process.

The 'Case for Change'

The case for change is clear and justified by the lack of compliance with NICE guidance, experiences of the clinicians consulted at the stakeholder meeting, conference calls, Cancer Peer Review findings and additional GM information/audits. The main reasons are:

- CFT and MFT currently do not provide an easy-access, fully integrated NICE IOG compliant HMDS, though there are areas of expertise in both organisations. The historical context has demonstrated lack of agreement on a model for a cohesive diagnostic service between CFT and MFT. This review has highlighted that this is the last opportunity for both organisations to work with GM cancer to agree and develop a GM solution for HMDS.

- Some of the referring District General Hospitals and the clinical teams in haematology within these organisations have opted to refer samples to Leeds HMDS in considerable numbers. This is estimated to be upwards of 3600 samples/year; over 600 are lymph node biopsies.

- This has significantly impacted on CFT and MFT activity levels for diagnostic samples. Continuing to follow the current approach will result in a future service that will be non-viable (i.e. small, expensive, limited repertoire and unable to effectively contribute to training and research).

- The complexity of haematological diagnoses with increasingly complex diagnostic, prognostic and treatment defined biomarkers (increasingly molecular) together with the requirement for the rapid development of new diagnostic repertoires and technologies. A long term strategy of investment and development of a properly integrated laboratory and processes is required to sustain a robust, resilient, efficient and effective diagnostic service for the future.

- The Addendum to the revised 2016 NICE guidance reiterated that discordance rates in diagnosis persist and evaluates the cost-effectiveness integrated models versus disparate models of diagnostic provision[(6)].

The case for change has demonstrated that there is an opportunity to create a single HMDS for GM and this is universally supported by clinicians, though the service must be:

- As comprehensive as that provided by Leeds HMDS to ensure repatriation of work.
- Provide ease of access with better use of resources through clear diagnostic algorithms.

- Provide a fully integrated report.
- Have improved MDT links across GM.

7. Detailed Summary of the Review Group following site visits

A. Summary of findings and themes from the clinicians/users of the current service, providers of the service and commissioners [Appendix 2].

- There is widespread frustration that it has not been possible to create an effective and cohesive SIHMDS between CFT and MFT.
- The absence of clear pathways, protocols and working practices between the two major providers has prevented services from fully meeting the needs of Manchester haematology and patients.
- Most of the hospitals have a variable and widely differing referral pattern of samples to diagnostic services and variable MDT links.
- Sample referral patterns differ between hospitals and even within single hospital haematology departments; different clinicians variably refer samples to CFT, MFT or Leeds.
- This is not an easy service for the haematologists as 'users' to access on behalf of their patients. There is no centralised reception for samples or streamlined sample flows and it is therefore difficult for the clinicians who often arrange transport of samples to 3 different laboratories for different tests and contact multiple laboratories for results.
- Development of laboratory expertise, technologies and test repertoires has been stultified by the longstanding lack of agreement about provision of services in the region; hence relatively high levels of samples are being referred outside of GM for some test types.
- An increasing number of clinicians are referring to Leeds HMDS though this is also not ideal as there is no specialist haematopathology input to MDTs.
- An integrated diagnostic service with algorithms for testing would lead to a more rational use of resources, fewer missed diagnoses, more relevant testing and better value-for-money.
- Lack of a coordinated GM service affects technical and medical training.
- Lack of a coordinated GM service undermines academic research development.
- Clinicians want a patient and user focussed service.
- There is support for services closer to patients that provide an optimised and close working interface between diagnostics, clinical service, research/academia and training/education.
- This would allow Manchester to emulate the great centres of the UK and across the world with high quality integrated diagnostics driving better patient care, research and trials recruitment.
- Research, translational development to service, and bio-banking are considered essential to long-term survival of clinical and diagnostic services; this is an opportunity to elevate the quality of R&D.

B Summary of themes from histopathologists providing the current service

- Variable local processing in most groups before referral to MFT, CFT or Leeds HMDS.
- There is no unified assessment and referral system in any sector.
- There are sampling and transport issues.

- Some delays in turn-round times from Leeds.
- Inefficient systems are limiting recruitment of samples to the 100k genome project. This may compromise the future Genomics England bid.

C Summary of Commissioning comments/views

- The team recognised that the building blocks are present to develop a compliant HMD Service in GM.
- The geography and catchment population (~3.3+m) was considered ideal for a self-contained GM service [APPENDIX 3].
- Reassured that clinicians were delivering services to the best of their ability but highlighted some concerns about the complexity and variation of arrangements that hospitals and individual clinicians had put in place.
- There is no standardised service for the whole population and this is an opportunity to improve on the situation.
- Future sustainability of services is important and depends on a new solution with the appropriate technologies and workforce.
- This is an area where patients are best served by the two GM providers working together collaboratively rather than competing for activity.

D Table of current referral patterns in GM by sectors

Organisation	Diagnostic sample referral patterns by sector
North East Sector Pennine (Fairfield, Oldham, Rochdale and NMGH)	Have moved immunophenotyping (IP) to Leeds HMDS. Cytogenetics referred to CFT and results then sent to Leeds HMDS for integration into final report. Molecular tests sent to Leeds. Histopathology looked at locally and some cases referred on to Leeds. If samples are not sent to Leeds HMDS, then they do not have an integrated report. No Haematopathologist input to MDT discussions from Leeds HMDS.
South (Stepping Hill, UHSM):	IP and cytogenetics to CFT Molecular testing to MFT or redirected to Leeds. Histopathology has variable local processing before sent to Leeds. No integrated report unless samples are sent to Leeds HMDS.
North West (Bolton, Salford, Wrightington, Wigan and Leigh)	IP referred to MFT Cytogenetics referred to CFT / Molecular tests referred to MFT Histopathology shows a variety of local processing, sometimes involving referral to Salford and then Leeds HMDS.

	Clinicians within the same hospital have differing pathology referral patterns and some send all samples directly to Leeds HMDS. No integrated report unless samples are sent to Leeds HMDS; variable depending upon clinician preference.
Central (Trafford, Tameside)	IP and molecular tests are done at MFT. Cytogenetics referred to CFT. Histopathology reviewed locally and then Leeds HMDS. Individual laboratories are helpful but not joined up. Needs a single joined up service embracing all diagnostic elements. No integrated report.
Manchester FT	Acknowledged the striking views of the referring DGH clinicians. Supportive of the move to an integrated HMDS service led by a single provider. The building blocks are all present in GM. Acknowledged that having two centres has produced organisational barriers to service improvement. The solution must lie in a partnership arrangement but how to deliver needs to be agreed.
Christie FT	Christie is a specialist hospital for tertiary referrals only. Laboratory services integrated with Synlab (Christie Pathology Partnership, CPP). Onsite immunophenotyping, cytogenetics, histopathology. Molecular to MFT and Germany (Cologne via Synlabs).

E Key summary of findings from interviews with clinical teams

Key themes of review findings	Summary of findings from review: Information provided
Clinician identified reasons for changing sample referrals from GM services to Leeds HMDS	Samples are distributed to too many different GM sites; this is time consuming, uses multiple transport routes and is not easy for the 'user'. Quality not to standard in GM due to: • Poor repertoire. • Reports not timely.

	• No integrated report. • No haematopathologist MDT input. A subsequent data search provided by Leeds HMDS IT department identified upwards of 3600 samples/year being referred from GM hospitals to Leeds HMDS; over 600 are lymph node biopsies and approximately 1000 samples are sent for a second opinion [Appendix 4].
Identified problems with Leeds HMDS	Transport and cost issues. Delays at the local histopathology departments (delay in referring to Leeds) and then delays in receiving the final report from Leeds HMDS. Impacts on MDT discussions and national targets. No input from Leeds to MDT meeting discussions and no opportunity to see the histopathology. Problems if samples do not have a Haemato-oncology diagnosis; sample returned and then need general histopathology analysis locally. Delays in the diagnostic process; limited local analysis performed initially and then referred on but residual sample left may be too small to analyse.
MDT processes for haematology	Very variable MDT links depending on disease. No input to MDT's from Leeds HMDS haematopathologists though they process an increasing number of samples. No single sector has a properly functioning and effectively linked diagnostic MDT process. MDT VC systems inadequate and will need unified to incorporate MDT data capture systems. Currently MFT and CFT have different systems.
Cancer Peer Review (CPR) Reports (2015) [Appendices 5.1 – 5.5]:	The comments from the Cancer Peer Review report documents of 2015 highlight the central importance of timely, accurate and easily accessible diagnostic reports to support the MDT and clinical decision making. None of the hospital MDTs perform well and Cancer Peer Review compliance varies from only 18% and 29% for the two lowest performers to a maximum of only 55% for the highest (National median ~60%). A selection of comments extracted from the CPR reports exemplifies a variety of the deficiencies from across GM:

	• Variable and fragmented diagnostic routes and multiple laboratories do not provide a fail-safe mechanism for identification of all cases of lymphoma. • MDTs have not been fully constituted and lacked a SIHMDS representative (not compliant with Cancer Peer Review measures) • There is no formal SIHMDS for Greater Manchester, which is out with the Improving Outcomes Guidance and leads to a fragmented service. • Diagnoses reviewed at both Christie and Leeds are not always concordant. • Samples are processed at a number of centres, for example, Leeds, CMFT, CFT, and therefore an integrated pathology report cannot be provided. The reviewers are concerned that this could lead to delays in diagnosis and therefore treatment planning. • Some clinicians are not core members of the MDT and only attend when they have patients to present. As a consequence these treating clinicians are not subject to the associated requirements of an MDT core member which may impact on the quality of treatment decisions and outcomes. • Some MDTs are only quorate for 27% of meetings for the reporting period. • Named core pathologist is not registered with a SIHMDS. • MDT meetings for all haematological disease types are not held on a weekly basis which is in conflict with the Improving Outcomes Guidance. • No core SIHMDS representation from Leeds at the MDT meeting which results in images of the diagnostics samples for RBH cases not being presented and there is no opportunity for case discussion of these samples.

Important issues identified for the future	Contribution of samples to the 100k genome project. National Importance of a successful tender for future Genomics England 'hub' status for Manchester and the Northwest (only 7 proposed in first round followed by a further reduction to 4 after 5 years). Training of SpRs – unable to provide specialist diagnostic training and poor exposure for what is now a standard part of haematology training. Bio-banking and future research (opportunity to repatriate samples sent to third party providers). If GM does not form a single, integrated, accredited specialist haematological malignancy diagnostics service very soon, it will have lost the opportunity to develop this. National Targets: 8 GM hospitals perform below the national average for the 62d target ~66 – 82% [GM Cancer Audit of 62-day target. APPENDIX 6]; delays at the local histopathology departments (delay in referring to Leeds HMDS) and then delays in receiving final report from Leeds HMDS. This then affects referral acceptance by tertiary care centres for a lymphoma diagnosis without a fully completed HMDS Leeds report.
General points raised	Concerns voiced by the clinicians that organisational barriers will stop the process again and this needs to be addressed. The review team and clinical teams agreed that the historical lack of progress was detrimental to service development, clinical service delivery, patient care, research and training. The service model must provide equity of access to a high-quality service i.e. timely, reliable and appropriate repertoire of diagnostic tests, for the GM population regardless of the point of presentation. Many diagnoses are not clear from the initial clinical assessment or diagnostic tests. Many cases of haematological malignancy are detected from samples sent from Primary Care. The ability to transfer such abnormal samples direct from General Haematology to the SIHMDS is a real benefit. A significant proportion of samples are referred from secondary care haematologists with no obvious diagnosis and come with clinical details such as 'pancytopenia, splenomegaly or lymphadenopathy'. This requires a close two-way interface between clinical haematology and the laboratory which may not be best served in a specialised, tertiary cancer referral centre which lacks the close interface with general haematology both diagnostically and clinically.

	If hospitals or groups currently source their diagnostics from a mixture of GM providers and an external provider, the optimal process should include all samples being transported and logged through a single GM Reception, even if they are subsequently forwarded to a third party for analysis. This would improve ease of use by clinicians, reduce transport costs and improve monitoring of sample 'send-aways'. The central coordinating laboratory can then assure the quality of external referral laboratory test quality, turn-round times etc on behalf of the user. As the numbers of 'send-aways' reduce and become limited to a small number of highly specialised tests, then the results from third party laboratories can be integrated into the final SIHMDS report. There is currently no agreed shared vision for the HMD service in GM.

8. Potential benefits

From the information gathered it is clear that there would be many benefits of working collaboratively within GM Cancer:

Category	Benefits
Diagnostic Quality Assurance	A high reputation, specialised, integrated diagnostic service with clinician expertise. Reduced variation in access to specialist diagnostics. An integrated report for clinicians, MDT discussions and improved patient care.
Patient Pathway	Easier access to a more co-ordinated, less fragmented and faster service. Reduced diagnostic turnaround times and delays in diagnosis. Improved MDT discussions, tertiary treatment referral times and treatment planning. Improved compliance with national cancer pathway targets. Reduced diagnostic variation to minimise errors.
Workforce	Improved recruitment and retention of a high quality, skilled workforce. Resilience to meet the needs of current and future demands on the services.
Financial and Operational efficiency	Value for money; reduced capital outlay and revenue expenditures. Improved operational performance Repatriation of samples from third party providers.
Education and Training	Optimised curriculum and clinical exposure for medical and technical trainees. Enhanced reputation of GM as a centre for training and work.
Research and Innovation	Increased research activity and income. Increased potential research material by repatriating samples currently outsourced to third party providers. A single point of entry for all clinical trials samples, thereby improving access to biomaterials. Link the integrated diagnostic service to bio-bank initiatives.

9. Service Model Options

The new service model for HMD services in GM must provide services for children, young people and adults. The recommendations are most likely to be achieved if the component parts of the specialist integrated haematological malignancy diagnostic services (SIHMDS) are located at a single site. The Following options were reviewed during this process by the review team:

1. **Option 1: No change**

This is not a viable, cost-effective option with 2 central laboratories only 2-3 miles apart. Continued processing of samples at multiple sites only promulgates a fragmented and reduplicated service with delays in diagnosis and treatment planning, effecting patient care. This model will not be supported by referring District General Hospital haematology teams. This is also not compliant with NICE guidance.

2. **Option 2: Rationalised/centralised GM service with a single Lead Provider**

This model is the only way to provide a fully compliant, timely, integrated, cost-effective service with long-term sustainability in the environment of the current national agenda for rationalisation of molecular services and the upcoming Genomics England tendering processes. Should utilise acknowledged areas of expertise within GM and built around the NICE guidance recommendations for a SIHMDS. This model would achieve compliance with NICE guidance.

3. **Option 3: Commission another SIHMDS provider**

All samples from all hospitals to be referred to another provider, for example Leeds HMDS. Other than **Option 2** this is the only other feasible option; it requires a properly contracted process implemented with another provider which ensures timely testing, the full repertoire of tests, acceptable costing/pricing and guaranteed input to MDTs to ensure the appropriate coordination, discussion and interpretation of results for clinical decision making.

This model would be compliant with NICE guidance but long-term, this option will not support or enhance the clinical services, training or research aspirations of the Greater Manchester clinicians and trusts for the benefit of patients and may lead to GM Cancer only providing a 'DGH-plus' service for haemato-oncology rather than being a centre of excellence.

10.Conclusions: Outcome of the review

This review confirms the GM Cancer aspirations of implementing a single NICE IOG compliant** service model. The Review Group unanimously agreed that the new service should:

- Be led by a single Lead Provider with a single GM Clinical Director.
- Utilise the current expertise within GM.
- Provide the highest quality, most efficient and effective service for clinicians and their patients.
- Implement within the most timely and cost-effective way.
- Rationalise laboratory technologies so that each modality is only provided by **one** laboratory.
- Implement an effective integrated diagnostic pathway with a single integrated report.

***Compliance should be designed around and assessed against the NICE 2016 guidance[3] [Summarised in APPENDIX 8].*

The review team summarised additional findings relevant to the review:

- The review team was highly supportive of a GM solution for haematological malignancy diagnostic services; if they could be assured that an appropriate, timely, high quality, cost-effective service would be implemented as a result.

- The review team agreed that the new service model would require clinical leadership, investment in resources and facilities. The new model will need robust clinical governance structures including cross-organisation contracts and appraisal processes for staff.

- The review team identified that Haemato-oncology is rapidly developing in GM and requires diagnostic services that are equally responsive.

- The review team identified that MDT reform must be incorporated as part of new service model, as the MDTs are intrinsically linked to the diagnostic patient pathway.

- The review team identified the need for a comprehensive IT system to be used, such as the Haemato-Oncology Diagnostic System (HODS) which is a widely recognised specimen booking, tracking and communication system for the safe generation and secure electronic distribution of 'integrated' SIHMDS reports. This will fulfil one of the key aims to inform referring clinicians on creation of the final report and enables integrated diagnostic processes and reporting.

- The review team identified that digital pathology systems are rapidly developing and need to be examined as a solution to some elements of multi-site working and supporting the MDTs, and must be considered integral in the development of the new service model.

- The review team identified that the sample pathways from DGHs, particularly for histopathology specimens, need to be reviewed to reduce local delays and provide uniformity of sample referral practice in line with NICE guidance [3] and [Appendix 8].

- The review team suggested that the DGH histopathologists and haematologists with an interest in haemato-oncology diagnostics should be incorporated into the HMDS structure with regular, rostered reporting duties. This will increase their expertise, involvement in the new model and enhance the input to the MDTs.

- The review team recognised that the new service model should be audited after implementation to confirm compliance with NICE guidance, improvements in turn-round times for initial diagnosis and national target (62-day target) compliance.

11. Recommendations

Following scrutiny of all the evidence gathered during the review period, the Review Team unanimously recommended that:

a. **MFT** should be Lead Provider for HMD services in GM.
b. **CFT** to be a key provider of elements of the service, including Cytogenetic and Lymphoma pathology.

In addition there is recognition that CFT is also a major user of the service and infrastructure arrangements should reflect this in the new model.

12. Decision making rationale for MFT as the Lead Provider

Following a presentation to both MFT and CFT on the 6th October by Dr Ireland, the following rationale for the above recommendation was agreed by the review group:

- Benefits of a primary care interface as well as secondary care interface between benign and malignant haematology services.
- Large, well established in-house transport and GPS tracking system with both routine and emergency pick up services.
- Large established specimen reception facilities.
- Scale, capacity, capability and resilience (current and future) of laboratory infrastructures, technology and staffing.
- Rapidly growing importance of molecular genetics in haematology diagnosis, prognosis and targeted therapies (MFT is the lead for the upcoming Genomics England tender).
- MFT has a large paediatric centre as well as large adult haematological malignancy practice and has the established expertise to deliver a diagnostic service for all ages.

13. Next steps

This report was submitted for ratification through the Provider Federation Board (November 2017) and will be submitted to the GM Cancer Board (January 2018).

MFT and CFT will begin a process of agreeing a strategic partnership board, a 'Terms of reference' and governance structure and an agreed timeline for implementation of the new model of HMD services in GM.

Acknowledgements: I would like to thank the host organisations and staff for their hospitality and contributions to the whole process and the Review Panel comprising the Patient representative (Sally Shelmerdine), the Clinicians (Dr Clare Barnes, Dr Chris Gregory, Dr Hayley Greenfield, Dr Simon Watt and Dr Sayee Chirputkar) and the Commissioning representative (Gill Barnard) who all gave up their time and contributed their expertise and knowledge and observations to the process. Their input was invaluable. Finally, Claire O'Rourke was essential to the organisation and smooth running of the review processes, logistics and meetings.

Dr Robin Ireland

Independent Review Lead

27th December 2017

Reference Documentation:

(1) Guidance on Cancer Services. Improving Outcomes in Haematological Cancers. The Manual. National Institute for Clinical Excellence. October 2003

(2) Additional Best Practice Commissioning Guidance For Developing Haematology Diagnostic Services, Gateway number: 1724, 2013

(3) Haematological cancers: improving outcomes. NICE guideline [NG47] Published date: May 2016. nice.org.uk/guidance/ng47.

(4) WHO Classification of Tumours of Haematopoietic and Lymphoid Tumours. S Swerdlow et al. IARC Lyon 2017.

(5) WHO Classification of Tumours of Haematopoietic and Lymphoid Tumours. Revised 4th Edition. S Swerdlow et al. IARC Lyon 2007

(6) National Institute for Health and Care Excellence. Haematological Cancers Addendum to Haematological Cancers: Improving outcomes (update). Service Guidance Addendum Methods, evidence and recommendations, May 2016.

Appendices:

Please note these are not contained within this paper, although referenced, but due to the volume used, they but can be received on request.

Greater Manchester Cancer

Paper number 7

Greater Manchester and Eastern Cheshire Cancer Intelligence

Clinical Outcomes, Performance, Patient Experience and GM Cancer Plan Metrics: January 2018

Key Messages

Domain	Outcomes and Performance Metrics RAG rating compared with England Average	better/same/worse than previous period
Prevention	GM&EC has 3.5% higher smoking prevelance than the England average but rates are declining. Three CCGs in the region have already achieved the 2021 target of 13%.	↑
	HPV vaccination uptake is better in GM&EC than the England average. Uptake ranges from 79% to 96% and 4 CCGs are already meeting the cancer plan objectve of 90%.	↑
Early diagnosis	Breast, cervical and bowel screening uptake are all lower in GM&EC overall than the England average. Although cervical screening uptake has dropped, breast and bowel screening rates and uptake are both improving.	↑
	GM&EC has a higher proportion of patients diagnosed at stage I & II than the England average and continues to improve.	↑
	Cancer mortality is gradually declining but rates are still higher in GM&EC than the England average; only 2 GM&EC CCGs have lower cancer mortality. Manchester CCG has the highest mortality rates as well as the highest cancer incidence, Eastern Cheshire the lowest.	↑
	Although GM&EC is still slightly below the England average for one year survival there was an almost 2% improvement on the previous year and the gap is expected to close by 2018. 3 CCGs have better one year survival than the England average.	↑
	The proportion of patients diagnosed via emergency admission is also improving. 5 CCGs have better rates of diagnoses through non-emergency routes than the England average.	↑
Improved and standardised care	GM&EC 62 day performance for October 2017 was again better than the England average and there was improvement on the previous month. 3 CCGs had under 85% compliance in October.	↑
Patient Experience and user involvement	GMEC patient experience has improved on the previous year and is better than the England average. All but 3 CCGs were rated as 8.7/10 or above	↑
All	Five CCGs have improved on previous year with 3 CCGs being rated as outstanding in the IAF assessment. 2 were rates as good and 5 require improvement	↑

Metrics Workbook


Cancer Intelligence -JAN2018 Report_1.›

Please note that due to the size of this file it may take a few moments to open. We are working on improving this. This workbook will form the the basis of the cancer intelligence dashboard currently in development.

The attached metrics workbook includes

- Cancer Plan objectives for GM
- Cancer Plan objectives for GM&EC
- Key CCG metrics aligned to the CG Cancer Plan
- Monthly and quarterly 62 day performance tables by CCG, Provider and cancer type
- Timetable for reporting of monthly cancer waits metrics

Progress with the development of the GM&EC Cancer Intellgence Service

An extract of data for all patients diagnosed in GM&EC between 2012-mid 2016 has been received from PHE to allow analysis of one year survival by CCG, cancer type and stage and GP referrals by stage. This work is now underway and initial analyses are expected to be presented to the pathway leads before the end of January.

Our application for data sharing between Providers and GM Cancer Vangaurd was submitted to NHS England for approval at the end of December and has been provisionally agreed subject to some additonal information being provided. We are currently working with our local DSCRO team to progress this.

Our host cloud environment is now in place and the structures for the dashboard feeds are currently being built. We hope to have some dashboard functionality in place by the end of February.

Challenges

Access to data is the main limiting factor to developing further timely and relevant cancer intelligence. It is vital to the success of this project that all Provider and CCG organisations are willing to engage with this project and share their data.

We are also dependent upon Informatics resources at The Christie to help progress the dashboard build.

The Cancer Board are asked to support the work to progress data sharing agreements between Providers, CCGs and the GM Data Services for Commissioners Regional Office (DSCRO).

Cancer Waiting Times Reporting Schedule

Reporting Month	Reporting Quarter	GM&EC Cancer Intelligence report distribution
Sep-17	Q2 17/18	Thursday, 9 November 2018
Oct-17		Monday, 11 December 2018
Nov-17		Monday, 15 January 2019
Dec-17	Q3 17/18	Friday, 9 February 2019
Jan-18		Monday, 12 March 2019
Feb-18		Thursday, 12 April 2019
Mar-18	Q4 17/18	Thursday, 10 May 2019

We would welcome any comments on the content and presentation of the data within this workbook. Please contact the GM Cancer Intelligence Team at catherine.ohara@christie.nhs.uk

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Paper number

8

Date: 3rd January 2018

Title: Achieving World-class Cancer Outcomes: Taking Charge in Greater Manchester 2017-2021 – Milestone Progress Report

From: Gill Barnard, Senior Programme Manager – GM Cancer Commissioning

Purpose of paper

To provide the Cancer Board with an overview of:

- Progress against delivery of the cancer plan milestones (Q3 – 2017/18)
- Expected milestone delivery over the life of the plan
- Progress against the objectives outlined within the cancer plan through the cancer intelligence report scorecard

Recommendations

The Greater Manchester Cancer Board is asked to:

1. Note the progress to date in relation to achievement of the cancer plan milestones

Contact

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Achieving World-class Cancer Outcomes:

Taking Charge in Greater Manchester 2017-2021

Milestone Progress – Quarter 3 2017/18

Domain	Theme	Item	Progress / Achievement	
Early diagnosis	Enhance cancer screening	Bowel and cervical screening improvement trials report findings	☑	Bowel screening 'predictiv' randomised control trial recruited 1600 people to test out 3 behaviourally informed letters. The most effective and statistically significant message was that of the 'certainty effect', removing uncertainty about cancer, which resulted in 8 .6% more people saying they intended to complete their screening compared to the standard letter. The report recommended also using the 'anticipated regret' message, which highlights the opportunity to avoid regret in case cancer is detected at a later stage in the future, in any new bowel cancer communications. Cervical cancer screening RCT was not authorised by PHE Research Advisory Committee, therefore GMHSCP are currently looking at alternative options to test behavioural insight theory with cervical cancer screening letters.
	Reduce diagnostic waiting times	Share learning on faster pathways locally and nationally	☑	The Faster Diagnosis project team are in the process of feeding back to the national evaluation team on the project so far. Interviews have been completed with commissioners, with further discussions to follow with operational and clinical leads. Whilst work still needs to be done on encouraging referrers to use the straight to test pathways, initial results are promising with time from referral to diagnosis halved for lower GI patients.
	Support pathway-	Pilot of straight-to-test	☑	The straight-to-test pilot is complete and the pathway board are now

	specific efforts to deliver earlier and better diagnosis	pathway for colorectal cancer		seeking to roll out the straight-to-test pathway for almost 70% of all GP referrals in 2018. Implementing straight to test is expected to reduce the time to diagnosis and treatment by 7-10 days on average.
Improved and standardised care	Complete the transformation of specialist urological and oesophago-gastric cancer surgery	Implementation plan for transformed urology cancer surgery agreed	☑	Urology cancer implementation board established. As this programme links to the theme 3 general urology work, commissioners have agreed that implementation must not destabilise the general urology service.
	Improve multidisciplinary team working	Need for MDT proforma standardisation assessed	☑	A review of multidisciplinary team (MDT) working across Greater Manchester's cancer services has been carried out with the following areas agreed for reform / development: • Agree MDT speciality attendance rates • Develop cancer pathway algorithms • Agree MDT proformas • Standardised approach to ensure MDTs review and learn from significant events • MDTs ownership of pathway performance against defined quality standards, and development of SMART quality improvement objectives
	Speed up pathways to treatment	50-day pathway in place in identified tumour types	☑	Best timed pathways for lung cancer formulate part of the national strategy for rapid pathway development and will be in place my March 2018. To review plan for 50 day pathway in HPB January 2018
	Review and strengthen pathway boards	Detailed plans developed for all priority pathway	☑	Detailed plans developed for all priority pathways (Lung, Colorectal, HPB, Urology and OG). Delivery plans for Lung and Colorectal agreed as priorities for additional support in 17/18.
	Deliver systemic anti-cancer therapies closer to	Action plan for implementation of the Greater Manchester	☑	Following approval of the SACT strategy an implementation plan and action plan will be brought to GM cancer board on the 9th Feb 2018. The plan highlights key target areas for providers to deliver and implement.

	home	systemic anti-cancer treatment strategy		
	Deliver an integrated acute oncology service	Commissioning plan for integrated acute oncology service	☑	Task and finish group established which have developed the standards, key performance measures, draft service specification. Pulled together by January 2018 and will be submitted to JCB.
Living with and beyond cancer and supportive care	Commission the Recovery Package	All patients receive a care plan at the point of diagnosis and treatment decision, and at the end of their treatment, based on holistic needs assessments	☑	The LWBC steering group and implementation group are monitoring progress against key deliverables within the GM cancer plan. A strategy has been agreed and is being implemented, with a series of pathway mapping exercises in Jan 2018 across key pathways, to review a gap analysis of service provision and agree the first steps to full implementation of the electronic Health Needs Assessment across GM, which is behind trajectory against plan. Several workshops and educational events have taken place in 2017 to support the roll out. A commissioning specification has been developed and is in final draft.
Commissioning, provision and accountability	Test the more effective use of cancer budgets	Detailed proposals for alternative budgeting, payment and contracting mechanisms for cancer	☑	A strategic approach to developing payment reform for GM has been described. It comprises 3 main tools Design Principles, the Commissioning Framework and the Five Area Framework. Next steps for this work are to publish the GM roadmap and best practice repository and establish a central GM payment reform team. The cancer payment reform model developed as part of the Cancer Vanguard will feed into the wider GM payment reform work. The model proposed has commissioners paying a cancer system "Supporting Co-ordinator" entity a block payment for services, and an additional gain share payment for early case finding. The Supporting Co-ordinator in turn pays providers with two types of bundles: 1) diagnostic stage and the treatment and 2) follow up stage of the pathway. Providers would receive an additional gain share from the Supporting Co-ordinator for reducing variation and making cost savings against the baseline position.
Patient	Improve our patient	System-wide cancer	☑	Met with GMHSCP Director of Nursing and agreed the establishment of a

experience and user involvement	experience	patient experience action plan		Patient Experience Strategic group by March 18. This group will be co-chaired by a person affected by cancer and the Terms of Reference and work plan for the group are in development.
	Ensure access to a CNS or other key worker for all patients to help co-ordinated their care	CNS and key worker access action plan	☑	Met with GMHSCP Director of Nursing and secured agreement that this will be overseen by the directors of nursing group, a steering group will be set up in Jan 2018 to progress.
Education	Create a primary care cancer education platform – “Gateway-C”	Additional Gateway-C modules and content developed	☑	Since Gateway-C’s launch, additional modules have been added on Pancreatic cancer (early diagnosis), Colorectal cancer (living with long term complications) and Lung cancer (end of life care). Early diagnosis modules on Brain and Hodgkins Lymphoma are currently in development and will be launched late February 2018.

GM Cancer Plan – Milestone Overview

Domain	Theme	2017/18		2018/19		2019/20		2020/21	
		Q1/2	Q3/4	Q1/2	Q3/4	Q1/2	Q3/4	Q1/2	Q3/4
Prevention	Raise awareness of lifestyle risk factors and change behaviour	●							
	Help people to understand their individual risk of cancer	●							
	Create a citizen-led social movement	●	●	●	●				
	Increase HPV immunisation uptake	●							
	Deliver lifestyle-based secondary prevention	●	●	●					
	Prescribe drugs that are effective in preventing cancers	●							
Early diagnosis	Enhance cancer screening	●	●	●	●	●	●	●	
	Increase public awareness of screening, and cancer signs and symptoms	●							
	Make the MCIP lung health check available to all if successful	●							

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		Q1/2	Q3/4	Q1/2	Q3/4	Q1/2	Q3/4	Q1/2	Q3/4
	Implement the NICE suspected cancer referral guidelines	●	●						
	Improve adherence to NICE suspected cancer referral guidelines	●							
	Develop rapid cancer investigation units	●							
	Pilot patient self-referral	●							
	Reduce diagnostic waiting times	●	●						
	Support pathway-specific efforts to deliver earlier and better diagnosis	●	●	●					
	Contribute to regional improvements in diagnostic services	●	●						
Improved and standardised care	Complete the transformation of specialist urological and oesophago-gastric cancer surgery	●	●						
	Transform breast cancer surgery	●							
	Improve multidisciplinary team working	●	●						

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		Q1/2	Q3/4	Q1/2	Q3/4	Q1/2	Q3/4	Q1/2	Q3/4
	Speed up pathways to treatment	●	●	●	●				
	Review and strengthen pathway boards	●	●						
	Agree challenging clinical standards	●							
	Deliver systemic anti-cancer therapies closer to home	●	●						
	Deliver an integrated acute oncology service	●	●	●	●				
	Develop the UK's first proton beam therapy service	●	●	●	●				
	Support and extend improvements to specialist surgical services	●	●						
Living with and beyond cancer and supportive care	Commission the Recovery Package	●	●	●	●				
	Develop new aftercare pathways	●	●	●	●				
	Explore supported patient decision-making in progressing disease	●	●						

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		Q1/2	Q3/4	Q1/2	Q3/4	Q1/2	Q3/4	Q1/2	Q3/4
	Improve access to psychological support	●							
	Commission a comprehensive lymphoedema service	●	●	●	●	●	●		
	Support people with long-term consequences of treatment	●							
	Earlier integration of supportive care into cancer care		●						
	Ensure access to seven-day specialist palliative care advice and assessment	●	●	●					
	Deliver choice in end of life care	●	●	●	●	●			
	Ensure that shared digital palliative and end of life care records are rolled out	●	●	●	●	●	●	●	
Commissioning, provision and accountability	Develop a cancer intelligence service	●							
	Test a new way of commissioning cancer services	●							
	Test the more effective use of cancer budgets	●	●						

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		Q1/2	Q3/4	Q1/2	Q3/4	Q1/2	Q3/4	Q1/2	Q3/4
Patient experience and user involvement	Define patient experience leadership	●							
	Better understand our patient experience	●							
	Improve our patient experience	●	●						
	Embed service users in the continuous development of services	●							
	Ensure access to a CNS or other key worker for all patients to help co-ordinated their care	●	●						
	Include cancer information in locality directories of services	●	●	●					
	Test innovative digital patient communications	●							
Education	Develop a cancer education and information strategy for Greater Manchester	●							
	Create a primary care cancer education platform – “Gateway-C”	●	●	●					
	Deliver coordinated cancer education for each cancer pathway	●	●	●					

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		Q1/2	Q3/4	Q1/2	Q3/4	Q1/2	Q3/4	Q1/2	Q3/4
	Deliver a comprehensive programme of cancer care education for personal and social care providers	●	●						
	Create a GM communication skills and patient experience training programme	●	●	●					
Research	Deliver the cancer themes of the Biomedical Research Centre	●	●	●	●	●	●	●	●
	Renew our National Institute for Healthcare Research Cancer Research Facility accreditation								