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 9th Feb 2018

Venue: Humphrey Booth Lecture theatre, Mayo Building, SRFT.

Chair: Richard Preece.

#	Item	Type	To	Lead	Time
1	Welcome and apologies	Verbal	-	Richard Preece	5′
2	Minutes of the last meeting	Paper 1	Approve	Richard Preece	
3	Action log and matters arising	Paper 2	Note	Richard Preece	
4	Update from GM Cancer User Involvement Steering Group	Verbal	Note	Sarah Haworth Nabila Farooq Ian Clayton	15′
5	Greater Manchester Cancer: Vanguard Innovation evaluation	Presentation	Update	Jenny Scott	15′′
7	62 day cancer standard: final report	Paper 3	Approve	Dave Shackley/ Susi Penney	20’
8	Resourcing the GM Cancer Plan and infrastructure	Paper 4	Approve	Adrian Hackney	10’
10	GM Cancer Annual Report	Paper 5	Approve	Dave Shackley	10’
10	Prostate Cancer ‘Best Timed pathway’ Update	Presentation	Update	Satish Maddineni	15’
11	Future Meeting Dates: ▪ **9th March 2018:** 8-10am ▪ **4th May 2018:** 8-10am ▪ **13th July 2018:** 8-10am ▪ **7th September 2018:** 8-10am				

Work Plan and agenda Items GM Cancer board 2018:

GM Cancer Board meetings		Standing Agenda Item	Work programme
9th March 2018	Frank Rifkin Lecture Theatre SRFT 8-10am	▪ GM Cancer Plan update ▪ User involvement update ▪ Vanguard Update ▪ 62 day update	▪ Single Surgery Cancer Implementation Programme Update ▪ Lung Cancer best practice pathway ▪ Recovery package ▪ Genomics Board presentation
4th May 2018	Humphrey Booth Lecture Theatre SRFT 8-10am	▪ User involvement update ▪ Cancer Plan programme update ▪ 62 day update	▪ Cancer Workforce Strategy ▪ Screening Action Plan update ▪ Acute Oncology commissioning specification ▪ OG Cancer best practice pathway update
13th July 2018	Frank Rifkin Lecture Theatre SRFT 8-10am	▪ User involvement update ▪ GM Cancer Plan programme update ▪ 62 day update	▪ Systemic Anti-Cancer Treatment strategy ▪ Lung Health Checks update ▪ MDT reform in GM
7th September 2018	Board Rooms 2&3 Trafford General 8-10am	▪ User involvement update GM ▪ Cancer Plan programme update ▪ 62 day update	▪ 100k Genomes update ▪ Psychological Support pathway Board: update ▪ End of life strategy and palliative care

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NHS in Greater Manchester

Greater Manchester Cancer

Paper number 1

Greater Manchester Cancer Board

Minutes of the meeting

Friday 12th January, Frank Rifkin lecture theatre, SRFT

In attendance

GM Health & Social Care Partnership Team		Richard Preece	RPre	Executive Lead for Quality, GMHSC Partnership (Chair)
GM AHSN		Donal O'Donoghue	DO'D	Medical Director, GM AHSN
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)	Darren Banks	BD	Director of Strategy
	Stockport	Helen Thomson	HT	Interim Chief Executive
	The Christie	Roger Spencer	RS	Chief Executive
	Pennine Acute	Roger Prudham	RPRu	Deputy Medical Director
Patients effected by Cancer		Nabilla Farooq	NF	-
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		David Shackley	DS	Medical Director, Greater Manchester Cancer
Director of Commissioning – GM Cancer		Adrian Hackney	AH	Director of Commissioning – GM Cancer, NHS Trafford CCG
Chair of Trust Directors of Operations Group		Andy Ennis (for Fiona Noden	AE	Chief Operating Officer, Wigan NHS FT
Nursing Leadership		Cheryl Lenney	CL	Chief Nurse, CMFT
Christie Hospital School on Oncology		Cathy Heaven	CH	Associate Director, Christie School of Oncology
Vanguard Innovation Programme		Jenny Scott	JSc	Programme Director, Greater Manchester Cancer Vanguard

Director			Innovation
Clinical Commissioning Group	George Ogden (representing Tracey Vell)	GO	General Practice
Lung Health Checks update	Gundit Bandesha	GB	Population Health Clinical lead
GM Cancer	Claire O'Rourke	COR	Senior Manager, Greater Manchester Cancer
62-day Presentation	Susi Penney	SP	Pathway Director head and Neck GM Cancer
Ryan Donaghey, Provider Federation Board		Catherine Perry, University of Manchester	
Rachel Allen, Population Health HSCP		James Leighton, GM Cancer	

Welcome and apologies

In the absence of RP, Rob Bellingham (RB) was in the chair and he welcomed all to the meeting and noted the apologies received.

Minutes of the last meeting

These were accepted as a true record of the meeting and there were no matters arising.

Action log and matters arising (Those not on the agenda)

- SACT review – Will be on the February Board meeting agenda
- MDT Reform – Will be on the March Board meeting agenda
- Action plan on screening - Will be on the March Board meeting agenda
- Genomics Board - Will be on the March Board meeting agenda

IC raised the previously agreed issue of Board papers carrying a statement the impact on patients and service users. He noted that this set of papers do not carry the statement and asked that this could be rectified in future meetings. RB agreed and confirmed that future meeting papers would contain this assessment.

Update from GM Cancer User Involvement Steering Group

IC presented this report and noted that the Vanguard and 62 day meeting report were on the agenda and so would cover these issues in those discussions.

Greater Manchester Cancer: Vanguard Innovation update

JS presented on the tabled paper. She explained that the Cancer Vanguard was a 2 year programme and due to end in March. She went onto outline what work and innovations that the Vanguard had undertaken and what it has achieved.

She explained that the main function was testing innovation at a concept level and if the concept could be reproduced at scale and could improve patient care. She confirmed the partnership arrangements and how the Vanguard functioned.

She listed the projects and provided a brief report on each. She went on to confirm that there was input from third party bodies such as the Pharmaceutical industry and Macmillan Cancer and thanked them for their support.

She acknowledged that with the dedicated team and budget, this allowed a faster pace to be adopted in innovating new concepts. JS then also acknowledged the contribution of the full range of user involvement guidance and support.

The next steps were that (1) At a national level, GM would co-lead the production of a national report and (2) complete the on-going evaluation.

In GM she confirmed that the work of the Vanguard was integral to the Cancer plan and the team would consider making recommendations to a future board as to which projects should have their funding continued by GM.

IC asked about the impact of the commissioning work stream of the Vanguard and as the Vanguard was to end in March he asked how this key strategic priority was to be taken forward?

RB responded by saying that a more substantial response would be brought to a future meeting. He went on to say that in GM there is a joint commission board that doesn't exist within any other cancer alliance. He then explained the GM commissioning Hub and how this infra-structure would support the commissioning process.

AH provided further detail on the hub and how this might improve and better support the system but recognised that there were still limitations such as lack of a single cancer budget and the lack of clarity on specialised commissioning. But he asserted that progress was still being made although not at the pace required.

IC responded that he welcomed this issue coming back to a future meeting but still felt that the accountability and user involvement could be improved.

AE agreed with much was said and suggested that this work should be integral with the work of the pathway Boards and roll-out should be linked with engagement at the PBs. This view was supported by SP, as a Pathway Director.

GO expressed the view that the system was changing and looking towards local care systems and local commissioning units , pointing out that cancer commissioning has an important local in addition to a GM aspect.

DD asked about the pathways the use of optimal times and whether consideration was being made to new innovations such as artificial intelligence to help facilitate care. DS & DD agreed to have further discussions on this point outside the meeting, recognising that with HiM and other mechanisms, GM was in a good position to test new technologies.
DS provided the meeting with a number of projects (Cancer Champions, Gateway C, Digital pathology and new models of diagnostics) that he felt only took place because of the Vanguard and felt that this was encouraging. He confirmed that the detail on these would be available in the annual report.

RB summed up the discussion by confirming that –

- Bring the discussion on commissioning back to a future meeting and link that discussion with what is happening at a local level
- GM Cancer must capitalise on the legacy of the Cancer Vanguard
- Be mindful of the development of artificial intelligence in medicine

JSh asked that at the future meeting of the Board there is a discussion on the Vanguard providing greater clarity would be provided on the next steps for the work of the Vanguard.

RB assured him that this would be on future agendas.

Lung Health Checks: update report

Gunjit Bandesha (GB) provided the first update on the lung health check project and assured the board that updates will continue regularly over future meetings.

She began by the background to the project and how it worked operationally. Then went onto to provide detail on the initial findings of the pilot and that of the cancers detected almost 80% were at stage 1 or 2.

She confirmed that uptake for the pilot programme was approximately 30% which was lower than seen in traditional cancer screening programmes but there were reasons for this and the capacity of the pilot programme was fully utilised. Uptake in future lung health checks may be expected to be higher (eg 40%+). One of the main successes of the initial pilot was to show that a large number of those scanned were from the lower socio-economic groups, traditionally seen as hard to reach in standard screening programmes.

The Board had a wide ranging discussion on what is the target population and was it preferable to just target the smoking population. GB went onto explain that if the risk score was raised from 1.5% to 3.0% at a GM level this would mean 85,000 lung checks would require 28,000 CT Scans and result in 1200 lung cancer cases being diagnosed. Approximately 800 0fwhich would need surgery.

GB summarised the project by describing the opportunities, challenges and next steps.

She explained that these were –

Opportunities –

- Reduce the number of deaths from lung cancer
- Make an impact in socio-deprived areas
- The number of co-morbidities identified
- Associated smoking cessation opportunity

Challenges –

- Incomplete evidence base,
- Public engagement,
- Management of co-morbidity,
- Radiology capacity
- Surgical capacity

Next steps –

- Greater engagement across the cancer system
- Plan a phased roll-out
- Engage with industry and commercial partners,
- Review the health technology,
- Undertake research and evaluation

JS asked if work had been done on how the cost base had this been affected by the shift in early diagnosis of lung cancer. GB confirmed that this was a complicated question and other factors needed to be factored in such as recurrence. JP said that this was crucial and essential work in order to fully understand the impact of the project.

RP asked if there was certainty on the reduction in mortality with the project. GB advised that there was a small risk of over-diagnosis of cancers that may turn out to be clinically unimportant (eg due to the presence of other co-existing more serious conditions, or tumours detected that turn out not to be life threatening). . She suggested further research and ongoing evaluation as the project acquires more data on outcomes. DS added that it would take 3-5 years to develop good quality survival data from the lung health check

project and that on current evidence alone there is sufficient a case to move forward with further testing and not wait for more data before (limited) roll out. Ongoing evaluation of all patients will be part of any agreed process.

GO advised that using spirometry as a dataset that is communicated to GP clinical systems would help to pick up COPD in smokers.

RB summed up the discussion by confirming that –

- The Board should be more engaged in this work and take a lead on where this going
- Work with the project steering group outside of the meeting to review the plans

62 day report: Cancer lead review of cancer systems in GM

Dave Shackley & Susi Penney provided an update on the review of the clinically led review of the clinical and managerial processes in delivering the cancer standards. DS also updated the Board on the subsequent related GM Provider meeting with Trust Cancer leads and explained the outcomes of the meeting. He confirmed that a number of themes emerged across the providers, namely;

- Broad agreement on having a 7 day standard (>90%) for all patients to have their first diagnostic or have their first clinical review
- Similar agreement on a standard that the time from requesting test to validated report is < 7 days (internal or external diagnostic test to that Trust).
- Daily triage of all 2WWs against standard protocol
- Open dashboard across GM for diagnostic tests
- Clear timed pathways for all tumour types, agreed by April 2018, and then subsequently commissioned to incentivise delivery
- Urgently establish a GM Radiology network as a priority, accepting that a digitised service is essential to deliver the full benefits of earlier specialist opinions, and also to facilitate testing of new anticipated technologies such as computer aided diagnosis

GO asked if there was data on GP conversion rates into Cancer and advised that the Board should see the data to identify variation and thus support the capacity available for the system.

RP suggested that commissioning and payments should be reviewed in light of the fact that more and more activity is done 'virtually' by clinicians outside of traditional clinics. SP agreed that this was evident as she undertook the review . AE concurred with this view and added that there was a need to look at alternative strategies, such as greater emphasis on early detection at primary care level.

RB summed up the discussion by confirming that –

- Recognise that due to the late paper he would accept comments outside of the meeting
- The Board should endorse this report
- The Cancer standards are high on the agenda of the HSCP
- That work should continue on delivery of the report recommendations

He expressed the thanks of the Board to SP for her work on undertaking this review

Resourcing the GM Cancer Plan and infrastructure

Adrian Hackney provided a report acknowledging that board members were increasingly concerned about the issue of cancer plan and infrastructure funding being resolved. He acknowledged that the Cancer plan to 2021 had been agreed in Feb 2017 and yet clarity on its funding beyond April 2018 was still to be formalised.

He explained that it is important to note the positive progress made in GM, for example in closing the gap in 1-year survival, but the goal was not just to get to the England average but to continue to lead nationally and we need to push on further and faster.

He provided a recap for existing and new Cancer Board members and explained :

Two issues associated with financial resource:

1. Resourcing the Cancer Plan – new / additional transformation and improvement activities
2. Resourcing the GM Cancer Team – pathways, cancer commissioning team (linked to the plan), user involvement

He went on to provide further detail on these items –

1. Resourcing the Caner Plan – new / additional transformation and improvement activities
   - The 'GM Cancer Plan' was produced during autumn 2016, with significant consultation through a variety of governance groups and committees and involvement of people affected by cancer
   - The plan was signed off by SPB and launched on 24 February and positive feedback was received regarding the content and presentation
   - This was the first 'alliance footprint' plan in the country
   - Following the plan's approval, a costed implementation plan was requested by the end of the summer (August)
   - Pending the costed plan, a 'placeholder' within the GM Transformation Fund of £4m was identified
   - Given the significance of cancer as the major cause of avoidable death in GM, the sum of the placeholder was questioned / challenged
   - The costed plan submitted at the end of August identified an investment requirement of £52m (from all sources) to implement the actions within the plan
   - The costed elements excluded two significant parallel programmes of work that were being picked up elsewhere, namely the Tobacco Control Plan and the Lung Health Checks project
   - Feedback has been received that the requests for transformation funding are greater than the available funding
   - Discussed with a number of executive leads within the GMHSCP
   - Discussion has commenced with localities and third sector partners regarding elements of the cancer plan and cancer must do's that have been built into existing plans
   - Bilateral meetings are being set up to review all 10 GM locality plans and the GM Cancer Plan to identify aligned priorities and the size (quantum) of any gaps
   - Presently uncertain regarding the availability and quantum of any transformation funding identified for cancer
   - Paper being discussed at the Transformation Portfolio Board on Tuesday seeking resolution to the uncertainty
   - Rob Bellingham agreed to escalate the urgency of getting resolution

2. Resourcing the GM Cancer Team – pathways, cancer commissioning team (linked to the plan), user involvement
   - Allied to the above the core GM Cancer Team has been funded non-recurrently on an annually reviewable basis
   - In 2017/18 the Team has received funding contributions from GM providers and commissioners, Macmillan and the National Cancer Vanguard
   - Funding from the Vanguard ceases at the end of March 2018
   - A proposal has been developed that seeks the same level of funding from providers and commissioners with a three year commitment in line with the plan delivery timescale
   - Macmillan is continuing to provide financial support for user involvement and patient engagement / experience
   - A balance of funding is sought from the Transformation Fund
   - This issue is now very time critical as due to uncertainty regarding employment

beyond the end of March, a number of team members have found employment elsewhere or decided not to extend secondments
- A further element to the funding ask is the request for a risk sharing agreement across commissioners and providers associated with the employer risks relating to the team
- Presently, these are being borne by the Christie NHS FT and NHS Trafford CCG
- This paper has been discussed and supported by DOCs and is now going to CFOs

He confirmed that whilst GM Cancer had achieved a great deal , such as one year survival improvements, and vast improvements in earlier diagnosis (by stage) , he advised that there was still much more to do. He went on to explain the process that he is following to secure funding. He advised that as CCGs undertake a review of their locality plans, cancer needs to be integral to these reviews.

RB reflected that actually this process will ultimately take the plan forward. Ongoing resolution of the degree of transformation funding and locality contributions is pivotal but a clear path for agreement has been described.

NG said that the move towards much of the cancer plan being funded by localities was not what was originally envisaged. The cross cutting theme of cancer made it more sensible to look at it from a GM perspective with GM funding/ standards, and not increasingly devolve to locality level where differences in standards of care/ outcomes could be increased due to differential funding positions/priorities..

RS said GM was leading the way in devolution. However this has meant that GM was unable to avail itself of the same opportunities as other alliances in easily accessing the 'ring-fenced' NHSE National Cancer transformation funding (GM expected amount approximately £12m) as cancer care must 'compete' with other aspects of the health and social care for any available funding. He suggested that even though GM was leading in many areas of cancer innovation, any inability to access at least the same level of funding as obtained by other alliances will put GM cancer services under more pressure and lead to GM slipping behind. He acknowledged the inherent difficulties in moving locality funding back into system funding, supporting the point made by NG.

DB asked if the Joint Commissioning Board (JCB) was looking at this issue and if certain principles were being used to address this and build some re-engagement with the cancer agenda. RB confirmed that he would be picking this up at the JCB meeting next week.

RB summed up the discussion by confirming that –
- Discussions with providers, commissioners would continue
- A written report would be provided for the February Board meeting

HMDS external review: report

Dave Shackley updated the Board on the HDMS service and spoke to the tabled report (for information in board papers) and asked the Board to approve the recommendations contained within.

DB said that it was important that all providers supported the new service and not just the Cancer Board. The Board approved the recommendations within the paper.

Papers for Information

- Cancer Plan: cancer intelligence report
- Cancer Plan milestone update

The Board noted these papers

Any other business

1. DS confirmed that a draft annual report would be circulated before the next Cancer Board.

2. JP updated the Board on Tobacco and two campaigns. She confirmed that this was a major campaign and would also advise on e-cigarettes and provide a telephone help line.

3. AH explained to the Board of the need to provide the infra-structure support for GM Cancer. He proposed that this should be for a three year period instead of annually as at present. He confirmed that a paper would be going to Director of Commissioning meeting this week.

NG asked for the costs of three year funding and AH agreed to provide this.

Greater Manchester Cancer Board

Action log

Prepared for the 9th February 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. Meeting to be convened with CCG teams and providers	3rd November 2017	SACT Strategy to be circulated to relevant groups update **July 2018**
3	Acute oncology: commissioning service specification to be completed	3rd November 2017	Update for Acute oncology and Paper for GM cancer board **May 2018**
4	MDT reform: DS to report back to GM cancer board in July on progress on pilots	3rd November 2017	Paper for GM cancer board **July 2018**
5	It was agreed and confirmed that future meeting papers would contain an impact assessment on patient outcomes and experience	12th January 2018	Confirmed this would be added to all board papers from Jan 2018
6	JP to provide an action plan and update on the screening to the GM Cancer board in May 2018.	12th January 2018	Paper GM board **May 2018**
7	Progress report on Genomics Board to report back to the GM cancer board in March 2018.	12th January 2018	Paper GM board **March 2018**
8	Infrastructure paper and report to be provided to GM cancer Board Feb 2018	12th January 2018	Paper for GM cancer board **January 2018**
9	62 day cancer standard report to be brought back to cancer board Feb 2018	12th January 2018	Added agenda item to board **February 2018**
10	Vanguard programme of work to be summarised and key actions and projects to be taken forward to be agreed.	12th January 2018	Added as agenda item to board **February 2018**

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number **2**

Greater Manchester **Cancer**

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	9th February 2018	
Title of paper:	Clinically-led review of Provider 62 day Cancer Waiting Time processes in Greater Manchester & Cheshire (GM&EC)	
Purpose of the paper:	To inform the board of the outcome of a clinically-led review of 62 day Cancer Waiting Time in Greater Manchester & Cheshire & approve recommendations	
Reason for Paper: *Please tick appropriate box*	✓	***Decision***
	☐	***Discussion***
	☐	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes	Earlier diagnosis and treatment for Cancer, increased capacity to see more new patients sooner and provision of rapid access to service for diagnosing cancer patients, with cancer intelligence data to support this.	
Improved patient experience	In GM&EC we will ensure that patients receive effective, efficient and safer Cancer services enabling them to receive treatment in a timely way, to reduce unnecessary delays and duplication, to improve experience.	
Reducing inequality	Ensuring patients can have cancer services that are locally accessible where possible, to reduce inequality in the communities that would most benefit	
Minimising variation	The recommendations of this review will ensure the current inequity across services in GM&EC is minimised, due to this being a whole system approach and which will be monitored through clear performance targets.	
Operational / financial efficiency	The review will drive service efficiency and sustain financial performance through service redesign of clinical pathways. Clinical teams who will redesign patient pathways will support the cancer waiting time targets and will ensure sustained performance.	
Author of paper and contact details	**Name:** Miss Susannah Penney **Title:** Lead Cancer Clinician - Tameside General Hospital & Pathway Director - Greater Manchester Cancer **Email:** Susannah.Penney@mft.nhs.uk	

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

DATE: 31st January 2018

SUBJECT: Clinically-led review of Provider Cancer Waiting Time processes in Greater Manchester & Cheshire

AUTHORS: Greater Manchester Cancer Team

PURPOSE OF REPORT:

The purpose of this paper is to summarise the findings, actions and key recommendations of a clinically led review of the 62-day Cancer standard and associated Cancer Waiting Time processes in Greater Manchester & Cheshire Trusts.

The review was undertaken by Greater Manchester Cancer, on behalf of the Greater Manchester Cancer Board and the Provider Director of Operations/COO Committee, and led by Miss Susannah Penney.

The preparation, review and subsequent consultation took place between June 2017 to January 2018. Consideration was given to the feedback from stakeholders including that obtained in a structured session of GM Providers in January 2018.

CORE RECOMMENDATIONS:

As a result of this review 12 recommendations have been agreed:

1. Clinicians must be more involved in 62d target delivery in Trusts. Clear reporting structures and accountability for Cancer leads within Provider Trusts should be established with regular patient tracking meetings, Trust level cancer board meetings and a clearly defined role for the lead clinician in 62-day cancer standard delivery.

2. Updated best practice guidance should be provided by the Pathway Boards of GM Cancer by April 2018 to ensure Providers are aware of the practice that should be implemented. Where straight to test solutions exist, these should be offered to suitable patients. These best practice pathways must be properly commissioned providing incentives to best practice at the earliest opportunity.

3. Stronger communication must be established between GM Cancer Pathway Boards and Provider Trusts. Cancer managers must be represented and involved in pathway redesign work. Pathway Boards should be aware of, and discuss the reasons and themes for patients breaching the 62-day target. Where possible, clinicians should be involved with operational managers in describing solutions to pathway problems.

4. Immediate review of Lung Cancer and Upper Gastrointestinal pathway performance and other key underperforming pathways against the 62-day standard should be undertaken. An action plan to implement the best practice pathways should be adopted

5. A maximum standard of 7 days from referral to 1st diagnostic or clinical review should be implemented. The target is >80% and all Providers should have an action plan to achieve this.

6. A method for transparent data sharing of diagnostic tests across organisations should be urgently implemented. This dataset must show data on specific diagnostic waiting times, time from request to validated report for all modalities and other key cancer performance metrics.

7. Diagnostic hubs, across multiple Providers, should be explored.

8. Standardised diagnostic turnaround times within provider organisations with ‘single queue’ methodology considered for all diagnostics where one trust performs tests on behalf of neighbouring trust patients.

9. A new target to be implemented across Providers of a maximum time from requesting of a test, to the availability of a validated report of 7 days (>90%). This would be for both internal and external Trust diagnostics.

10. All Providers must ensure that they have 52 week coverage of all cancer pathways within their organisations with arrangements in place for MDT’s to function at least weekly, and appropriate cover processes described.

11. Strong consideration must be given to GM urgently setting up both a (i) digital pathology, and (ii) digital radiology service. These both have 2 elements, namely digital image sharing, and virtual networks for reporting. Some progress is being made in radiology but pathology progress is less visible.

12. Regular Provider / Clinician Forums should be in place that encourage sharing of good practice between Providers. Greater Manchester Cancer should lead this.

CONTACT OFFICERS:

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Miss Susannah Penney, Lead Cancer Clinician - Tameside General Hospital and Pathway Director - Greater Manchester Cancer
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BACKGROUND:

Achievement of the national cancer waiting times (CWT) 62-day standard is considered by patients and the public to be an indicator of the quality of cancer diagnosis, treatment and care NHS organisations deliver. Delivering timely cancer pathways is crucial for the following reasons:

- Despite improving survival rates, cancer is the fourth leading cause of death in the UK
- Patients continue to present late to their GP with their symptoms, resulting in delayed referral
- There is variation in 2 week wait (2WW) referrals across the country suggesting that GPs are not always identifying suspicious symptoms
- Where the diagnosis is cancer, a speedy diagnostic pathway is critical for 62-day compliance.

Greater Manchester and Eastern Cheshire (GM&EC) Trusts have consistently achieved the 62-day referral to treatment standard since the inauguration of the breach reallocation policy in October 2011. A considerable amount of work has taken place on cancer pathways in GM&EC and there is evidence of significant collaboration between provider Trusts to ensure the 62-day cancer standard is maintained.

Sustainability of the 62-day cancer standard in GM&EC has become increasingly challenging in order to maintain performance above the 85% target, with a need to provide assurance of this in the longer term. A key priority of the Director of Operations/COO Committee and Greater Manchester Cancer Board is the assessment and monitoring of the 62-day cancer standard. Difficulty with maintenance of the 62-day cancer standard has been exacerbated by:

- An increase in 2WW referrals (approximately 30% in the last 3 years)
- Increasing complexity of patients health needs
- Identified resourcing gaps in specific areas such as pathology and radiology diagnostics.

This review of the 62-day cancer standard in GM&EC has been conducted in collaboration with:

- Greater Manchester Health and Social Care Partnership
- Greater Manchester Cancer
- Manchester Cancer User Involvement and patients Affected by Cancer
- Directors of Operations/COO Committee
- Hospital providers
- Trust Cancer Leads (lead clinicians, lead cancer nurses and cancer managers)
- Commissioners

ACTION TAKEN:

Greater Manchester Cancer on behalf of the Director of Operations/COO Committee and the GM Cancer Board undertook a review of the current constraints to the delivery of the 62-day cancer standard in GM&EC in June 2017.

The review was led by Miss Susannah Penney, Pathway Director of the Head & Neck Pathway Board/Lead Cancer Clinician, Tameside & Glossop Integrated Care NHS Foundation Trust.

She visited each provider in GM&EC and met with a range of staff within each Trust, specifically with the Trust Cancer lead, the lead Cancer Nurse and the Cancer Manager.

The following actions and meetings were planned as part of the review process:

Actions	Date (2017-18)
Reviewer identified to lead review of 62-day cancer standard	June 2017
Interviews and site visits conducted by Miss Susannah Penney to all provider Trust in GM&EC	July-September 2017
Summary Paper circulated to Director of Operations/COO Committee and providers Trusts in GM&EC	September–October 2017
Presentations of finding to GM Cancer Board and recommendations to set up meeting with key GM&EC provider and cancer leads	3rd November 2017
Presentation and discussion at Director of Operations/COO Committee, meeting date for Trust Cancer Leads set and attendance agreed. Letter sent to all Trust leads to request attendance.	10thNovember 2017 15thNovember 2017
Meeting of Trust cancer leads	8th January 2018
Summary of outcomes of cancer leads meeting to GM Cancer Board	12th January 2018
Preliminary findings and summary paper ratification at the GM Cancer Board.	9th February 2018
Follow up cancer leads meeting to evaluate actions against recommendations	April 2018
Monitor of performance against recommendations to GM Cancer Board.	April 2018 June 2018 September 2018

SUMMARY OF KEY FINDINGS:

The summary of the key findings from the site visits to Provider Trust in GM&EC were put into 3 key themes (more detailed information is provided in the table below):

- **Theme 1 – Provision of System wide assurance**

Key actions:

- Identify and agree new external verification process required across GM to maintain delivery of high quality cancer care and ensure support for providers to enable continued delivery of the 62-day standard.
- Transparent sharing of data and reporting mechanisms to Director of Operations/COO and Cancer Board

- **Theme 2 – Responsibility of GM Cancer and the clinical Pathway Boards**

Key actions:

- Stronger and easier communication between Pathway Boards and Provider Trusts
- Clearly documented sharing of information and Pathway Directors/ Board members taking responsibility for this
- Cancer Manager(s) from a Provider Trust should attend relevant Pathway Boards to provide expertise on 62-day cancer standard
- GM Cancer to produce a clear job description of the clinical cancer lead and accountability and responsibilities
- Pathway Board to clearly share innovation, good practice and proposed changes to clinical pathway to all provider Trusts including a clear operational timeline for best practice pathways
- Pathway Board is to support provider Trusts that are failing the 62-day cancer standard with an expert review and support team to be implemented.
- To ensure all Pathway Boards have set clear quality and operational standards

- **Theme 3 – Responsibility of Individual Provider Trusts in GM&EC**
  - All patients to first seen (or 1st diagnostic) within 7 days**, a**greement to be set at >80% across provider Trusts. Implementation plan to be agreed.
  - Senior Clinical Triage of referrals every working day and very clear evidence of close working relationship between lead cancer clinician, nurse and cancer manager as well as involvement of clinical tumour site leads.
  - All-in-one diagnostic hubs/diagnostic days to be strongly considered. Opportunity to work with neighbouring providers on this.
  - Agreed set turnaround time for diagnostics should be agreed between the clinical team, cancer services and the diagnostics teams and must be a maximum of 7 days (>90%) from requesting a test to the validated report being available

- An agreed dashboard for sharing information between lead cancer clinician, lead nurse, cancer manager and information shared with pathway boards
- Improved collaboration between provider Trusts that share pathways and feedback mechanism of this to Pathway Boards
- Provider Trusts should ensure that clinicians managing cancer services within organisation should be supported by a robust decision making and governance structure.

Theme 1 Recommendation	Issue Identified	Summary of findings	Action
1	**GM peer review of performance, patient experience and individual service from tumour teams.** Although Trusts are still required to upload information to the Quality Surveillance information system (QSIS) the amount required is far less than it has been in the past. Many trusts still perform internal peer review led by either their lead cancer clinician or lead cancer nurse in conjunction with the cancer services manager. This is no longer an externally validated process and is very variable between trusts. There is a perception that the lack of external oversight has, in some cases, made this more of a paper exercise.	When discussed with Cancer Service Manager's (CSM) and Director of Operations (DoO) an internal GM peer review process was an attractive option with trusts within GM (&EC) holding each other to account against a set of standards. This will need to be described more thoroughly but should focus on performance, patient experiences and adherence to gold standard practices (generic GM standards and individual pathway board standards). To ensure parity of assessment this should be overseen by GM Cancer and the results reported to the GM Cancer Board.	**New GM Cancer review system required and to be agreed to support delivery and maintain standard.**
2	**To hold Trust accountable for their performance and service** Although trusts report to NHSE around the 62-day standard it is completed and actioned by all providers, there are unique opportunities within Devolution Manchester and the Cancer Vanguard to aspire to the highest standards of care. We should be striving toward all patients being treated in an expedient fashion with high quality diagnostics and treatments at the forefront of what we do.	62-day is a part of our clinical pathways and there needs to be responsibility and accountability at a GM level for the care we provide. We need to scrutinise practices within all our trusts to ensure the best for Manchester cancer patients. GM Cancer is in a position to oversee this and act accordingly to maintain high standards of care.	**Transparently sharing more data on diagnostic and treatment times, including endoscopy, radiology and pathology waiting and reporting times**

Theme 2 Recommendation	Issue Identified	Summary of findings	Action
3	**There is little or no formal communication between Pathway Boards and Trusts.** Trusts very much rely on the attendance of its employees at pathway board meetings to feed-back relevant information. This is unreliable, as attendance can vary dramatically and there is often no internal mechanism for the feedback of information within organisations.	GM Cancer needs to ensure a robust method of communication from pathway board to trusts to ensure the accurate communication and implementation of changes to clinical pathways and standards of care. There also needs to be a process by which trusts which require support from a specific pathway board can approach that board and participate in its work or make suggestions to improve the pathway and patient care.	**GM Cancer senior team to ensure Pathway Director and Pathway Board members action this.**
4	**To share learning and good practice**	There are many changes to cancer clinical pathways across GM&EC and many initiatives that trust/clinicians/AHP's and patients could get involved in. It is GM cancer's responsibility to ensure that this information is shared to the wider audience so trusts and individuals can become involved at the earliest opportunity to help innovate and deliver world class cancer outcome.	**GM Cancer establish a means by which information is shared to the wider audience so relevant NHS professionals and patients can become involved at the earliest opportunity to help innovate and deliver world class cancer outcomes**
5	**Monitor attendance and provide trusts with feedback around poor engagement**	In order to provide high quality care and be able to interact well with trusts it is important to ensure adequate representation. Pathway Boards should also be a place where business decisions can be made so they need to be functional – too many members will preclude this. Responsible clinicians need to attend, and this should be monitored, particularly if a trust is underperforming. Issues should be escalated to the GM medical director and the relevant Trust's lead cancer clinician.	**GM Cancer Pathway Boards provide support and assistance to organisations delivering the specific pathways where required**

6	**To ensure performance discussed at Pathway Board level with the support of a Cancer Service Manager**	Performance of the clinical pathway for each tumour group should be a standing agenda item on each meeting of the Pathway Board and clinical pathways should be continually reviewed. If a new step in the pathway is introduced which changes it significantly, a discussion around when a CARP should be submitted should be had between the clinicians and their resident CSM. All boards with responsibility for a clinical pathway should have representation from a CSM. Clinicians need to be made familiar with Manchester's breach reallocation policy between trusts.	**Cancer Service Managers are included in all clinical pathway revision projects work**
7	**To set terms of reference for clinicians leading on cancer within individual trusts and provide support for the clinicians and trusts**	There is a wide variation around the clinical leadership for cancer across Manchester. Clinicians are under huge pressure in terms of their clinical work and there is a feeling that 62-day has become a 'managerial' target in many trusts. Many lead cancer clinicians and tumour clinicians do not have a formal job description and there is wide variation in the amount of time that clinicians are given to devote to their cancer workload. Clinicians appear, in some cases, to have become disengaged from the 62-day process and are frustrated with diagnostic delays which they perceive are outside of their control. Decisions about clinical pathways are ultimately a clinical responsibility and clinicians should be encouraged to develop them around a gold standard timeline provided by the relevant pathway board.	**GM Cancer to coordinate and co-produce a universal job role specification for Trust Lead Cancer Clinicians**
8	**Provide shared learning events throughout the year for LCC's, CSM's and Pathway Directors to share good practice and knowledge around changing clinical pathways**	There is much silo working both within trusts and between trusts. GM Cancer is in a position to provide a platform for knowledge exchange. They also have a responsibility to communicate changes relevant to cancer pathways and care across the Manchester conurbation	**Pathway Boards to organise pathway learning events for the relevant stakeholders**
9	**Education of Pathway Directors/Lead Cancer Clinicians around the 62-day standard and ensure that that knowledge is shared.**	Many clinicians remain unaware of the intricacies of the 62-day pathways and the breach reallocation policy. It is vital that they understand how the 'system' works in order for them to have control over the clinical pathways. Misunderstandings lead to poor relationships between clinicians and managers as well as poor performance against the 62-day target	**Trusts to organise pathway learning events for the relevant stakeholders within their organisation or across shared pathways**

10	**To provide succinct minutes and actions that can be fed back to trusts for implementation**	Action plans should be generated from meetings along with minutes. These should be available within two weeks and sent to the GM Cancer administrative team to allow dissemination to all trusts.	**GM Cancer Pathway Boards should communicate the meeting actions to Trust Cancer management teams within 2 weeks of the meeting.**
11	**To consider innovative ways to ensure that an increasing number of referrals can be dealt with in a timely manner by trusts**	The number of patients referred with a possible cancer is increasing. We are obliged to make accurate diagnoses and perform appropriate treatments in an ever-shortening time frame. Clinicians and managers need to work together to think of new ways of managing these clinical pathways and these should be shared at pathway board meetings to ensure that changes are safe and appropriate to patient care. This also allows the sharing of good practice across the city.	**GM Cancer Pathway Boards should provide Trusts with a forum for sharing of practice and innovation and then further communication to stakeholders**
12	**To set gold standards of care co-produced with patients**	Each diagnostic clinical pathway needs to be set by the pathway boards and advice on implementation given. It should be made available to GM Cancer and disseminated to lead cancer clinicians, lead cancer nurses and CSM's. It is the responsibility of GM Cancer to ensure this information is updated by the pathway board as required and disseminated appropriately. Where possible, timings of diagnostics on the pathways should be pre-determined e.g. scan by day 10 etc.	**Pathway Boards to agree and publish a set of quality operational and clinical standards for each tumour specific pathway**

Theme 3 Recommendation	Issue Identified	Summary of findings	Action
13	**Senior clinician triage – up front investigations wherever possible**	There are a number of reasons that this is important. The onus is on primary care practitioners to refer patients with a >3% suspected risk of cancer. This has led to a sustained increase in the numbers of patients being referred – the vast majority of these are appropriate. However, there are small numbers of patients in each speciality where the referral is inappropriate. It is vital that this is highlighted to the relevant primary care physician as part of a learning exercise as well as assisting with preventing the system from being overloaded. In certain pathways the clinician may be able to institute initial investigations up front, designate that the patient is suitable for 'straight-to-test' or assign the patient to a specialist 'one-stop' clinic. This can take time and job plans should be altered accordingly depending on numbers of referrals to the service and the number of clinicians performing triage.	**Where clinically appropriate a single point of triage in each pathway (in relevant trusts receiving referrals) should be established to initiate investigation or referral to the most appropriate clinics.**
14	**Ensure collaboration between trusts that share pathways**	The cancer waiting times document makes it clear that the timely treatment of cancer patients is a shared responsibility between trusts and that this should be done in a collaborative fashion. Although a breach will be allocated to either one or a number of trusts it should be of paramount importance that patients should be treated with equal priority whether they are CARP'd on day 41, 42 or 43. This needs to be monitored and GM Cancer should have oversight of this data. The definition of a breach should be well defined – CARP's should be clinically guided. If a clinician has accepted a patient for treatment then the trust should accept the CARP – if the CSM is not happy with this it should be discussed with the lead tumour clinician, and the lead cancer clinician	**GM Cancer Pathway Boards should work with Providers and monitor breach reallocations for each tumour specific pathway**

15	**Advice and guidance portals, direct conversations between GP's and consultants prior to referral STT or one-stop models wherever possible**	Primary care physicians can be unsure about how to apply NICE guidance to referrals or what to do with patients who fall outside of the guidance. Some can also refer inappropriately. An advice and guidance portal in each trust where primary care physicians can post questions that will be answered within 24 hours to guide whether referral or other investigations/treatment strategies are appropriate should be instigated. Open discussion with specialists around patient care can facilitate the direct booking of appropriate investigations and instigation of treatments. This may be supplemented by risk assessment tools such as the REACT programme.	**Trusts to establish an advice and guidance portal so that primary care physicians can post questions that will be answered within 24 hours**
16	**Direct booking of investigations – radiology, endoscopy, diagnostic biopsies etc and visible to managers and clinicians**	An internal rolling capacity and demand process should be implemented. Pressures on diagnostic services that are struggling should be elevated to an executive operational level for scrutiny and solutions. Easy to see dashboards with the time to scan, time to report (pathology and radiology) along with performance should be readily visible and available via trusts information services. Protocols should be embedded on both a clinical and a managerial level. If patients are seen in consultant clinics for their first appointment they should leave the trust with the dates for their initial investigations and procedures written down. This gives them confidence in the system, ensures that appointments are received and also allows the clinical team to control and map out the subsequent part of the pathway.	**Set turnaround times (request to report) should be agreed between the clinical team, cancer services and the diagnostics teams - this applies to radiology, pathology and endoscopy particularly.**
17	**Ensure adequate diagnostic capacity, sharing of skills, no duplicate investigations or reporting (especially radiology – needs GM wide solution)**	Dashboards should be reviewed regularly by the lead cancer clinician, CSM and lead cancer nurse. Persistent issues should be elevated to an executive operational level for scrutiny and solutions. Dashboards should also be readily visible to the trust cancer board	**A diagnostic dashboard should be available and reviewed regularly by the lead cancer clinician, CSM and lead cancer nurse within organisations.**

18	**All-in-one diagnostic hubs/diagnostic days**	Many pathways are complex for patients to navigate. There are instances where cancer is confirmed but suitability for treatment and the nature of that treatment is dictated by a number of further investigations (e.g. OG). Trusts are often dependent on other providers for these more complex diagnostics, but the overall patient pathway remains the responsibility of the referring trust, despite them having no control over when the investigations take place. Patients can be required to attend a number of different sites on a number of different days which leads to problems with appointment clashes, travel issues, all of which lead to poor patient experience as well as delays. It would be more efficient to look at different ways of providing these services in a conjoined way across the city – perhaps looking at the sector version modelled in lung where patients attend a diagnostic hub and have their investigations performed all in the same day so far as is possible. The Healthier Together reorganisation of services will create opportunities for trusts that have lost some activity to potentially setup these diagnostic centres supported by specialists clinical input and in collaboration with treating trusts. Easy to see tracking – day 7, 19, 28, 42 etc. MDT co-ordinations and trackers actively promote 62-day pathway timelines at regular meetings especially MDT. Trusts where the MDT co-ordinator and tracker is the same person (if the PTL too big then they should essentially sit at the same desk) perform better than those where the roles are dissociated. Tracking should be visible at every hospital visit both to the administrative staff and the clinicians. Regular PTL meetings with clinical involvement are vital, as well as the inclusion of the diagnostic specialities so specific actions can be taken away from each meeting and completed. PTL's should be reviewed daily by the cancer services team and problems swiftly elevated to the responsible clinical team. Clinicians should be given time in their job plans to manage PTL's with cancer services and be trained in the use of Somerset (or other relevant tracking software).	**Trusts should review PTLs collectively and have escalation processes in place to address risks and issues** **The MDT co-ordinator function and the tracker function should be aligned where-ever possible**
19	**In depth analysis of all breaches to be shared between clinicians and**	Breach analysis remains essential. Problems are often cross-speciality or cross-trust. Themes should be	**Trusts should review breaches with all relevant specialities and/or**

	managers and to work together to provide solutions to hold-ups	identified, and actions taken. Breach themes need to be subject to cancer board and executive leadership scrutiny to ensure timely solutions to recurring problems.	**organisations** and **have escalation processes in place to address risks and issues**
21	**Sharing of good practice between specialities**	It is the role of the lead cancer clinician to ensure that good practice is shared across different tumour sites within their trust. This can be via internal communication or more formally at cancer board.	**Trusts should have a process to share good practice and advice within the organisation and across specialities.**
22	**Regular cancer boards with engaged clinicians**	Cancer Board meetings from an integral part of performance review, breach analysis, the sharing of good practice and problem solving. They should take place regularly at pre-determined times and clinical representation is essential.	**Trusts should have formal and regular Cancer Board meetings, working to a GM agreed set of terms of reference**
23	**Job planning for lead cancer clinicians and lead tumour clinicians with defined roles and responsibilities, regular appraisal and re-application to ensure continued engagement**	Managing clinical pathways for cancer, taking responsibility for performance and ensuring the continued development of high standard cancer care requires time and commitment. There should be direct reporting to an executive (Medical Director/DOO's) and an annual appraisal. Re-application (as with many clinical manager jobs) should take place regularly to ensure that standards remain high, new ideas and new people can participate in cancer care. Tenure should be discouraged.	**Lead Cancer Clinicians should report to the Trust executive and have regular appraisal to ensure support is provided.**
24	**Adherence to 7/7 target**	Trusts should aim to see the vast majority of patients for their first visit (STT/OPD/Ix) at less than seven days. This allows more time for complex pathways and ensures patients are not left feeling uncertain once primary care has referred them.	**7/7 target to be achieved**
25	**Complete control/ownership of in-house pathways e.g colorectal, haematology at MRI etc.**	Some pathways take place completely within one trust. These should be closely managed as the trust has complete control over the patient pathway. Only very complicated patients should breach and there should be no operational delays.	**All single Trust pathways should be managed appropriately to ensure successful delivery of the standards**

26	**Early specialist advice for complicated pathways**	Many complex pathways start in a diagnostic trust and referral to the treating trust cannot take place until criteria have been met to generate a CARP. Prior to this point on the pathway, the referring trust clinicians should have open access to specialist advice (this should not have to wait for an MDT discussion and then further investigations ordered). There needs to be an efficient way of communicating between referrer and receiver. If a trust has a visiting specialist clinician (e.g. OG at SHH) they should have the overarching responsibility for that clinical pathway.	**Collaborative processes need to be established between across 2 / 3 trust pathway services so that the referral of the patient is managed correctly**
27	**Low patient volume cancers – (central triage as for brain and CNS at Salford)**	Some trusts only get a very small number of highly specialised referrals – could these be centrally triaged by the specialist centre (sector based?) to ensure the patient gets to the correct clinic with the correct investigations.	**Those cancers that have low referral numbers should be identified and agreed to allow a revised pathway to be explored**
28	**Regular meeting of Cancer service managers, Lead Cancer Nurse, Lead Cancer Clinician**	This triumvirate is key to the 62-day performance as it ensures problems are sorted quickly and services closely monitored. It needs to report directly to the trust board.	**Each Trust will establish a regular operational meeting to review performance against the standard**
29	**Education of clinicians around 62-day and breach re-allocations**	It would appear that many clinicians have little understanding of the 62-day cancer standard and of the breach reallocation policy that exists in GM. Trainees/staff grades have even less idea, yet all see cancer patients on pathways. On-going education is required to dispel myths ('you can't step a patient down until it's been through an MDT' or 'what's a breach reallocation policy?'). 62-day performance should be part of the induction for all cancer clinicians and for all new staff that will see cancer patients.	**Each Trust should have a regular education programme for clinicians and associated staff on the national cancer standards and their delivery.**
30	**Ensure Trusts are represented on Pathway Boards and that clinicians attend regularly and feedback information to CSM, DOO's and LCC. Monitor attendance at the boards.**	If clinicians are given time to participate in pathway work then this should be facilitated by the host trust (not saying that the clinician can't go because of pressures) and the clinicians should make the effort to attend. Attendance should be monitored on an annual basis – persistent non-attenders should be tackled and if necessary asked to step down and the trust should nominate a replacement. It would be sensible for the trusts representatives to rotate after a few years to allow new ideas.	**Trusts should provide representation and monitor attendance at the Pathway Boards**
31	**Clear escalation policy to senior management when parts of a**	Cancer is a fundamental part of a trusts workload. Any issues that cannot be resolved should be	**Trusts should ensure that clinicians managing cancer**

	pathway not working	escalated/reported to the trusts executive board. Cancer services should be supported by a governance structure that is overseen at the highest level. Where this happens, performance is excellent – where this is lacking, performance has been poor. Strong clinical and executive leadership working together is vital. Engagement of clinical teams is essential, without clinical accountability and co-operation these clinical pathways will continue to challenge and, in some areas, continue to fail. 62-day is a clinical concern that has fallen away from clinicians. Clinicians need to regain oversight and work to improve the standards of these pathways with the support of their management teams. They need adequate time in which to do this. All clinicians have an annual appraisal – for cancer clinicians this could be more focussed, and PDP's should reflect ongoing plans for the improvement of cancer care. Clinicians should be empowered and feel proud to lead for their tumour group or trust and this will be reflected in their performance.	**services within organisation be supported by a robust decision making and governance structure.**

NEXT STEPS:

Following the publication of the above recommendations to the Director of Operations/COO Committee and GM Cancer Board, a meeting was convened with all the Trust Cancer leads: lead cancer clinician, lead cancer nurse and lead cancer manager on the **8th January 2018**.

The feedback has been collated into 3 sections:

1. **Table 1 -** Provider Trusts feedback on the recommendations in the report and their priorities.
2. **Table 2 -** Summary of provider Trusts good practice within their organisation and their current organisational challenges.
3. **Summary of Actions** - Agreed feedback on actions for each provider Trust.

Table 1:

	High scoring recommendations	**Scoring 1-2 for the recommendation**	**Low scoring for the recommendations**
Responses	1.That Cancer Service Managers are included in all clinical pathway revision projects / work	1.Robust and supportive communication channels between providers and the pathway board	1.Organisational pathway learning events are organised for the relevant stakeholders to share learning and identify issues
	2.There is open sharing of data within the system on diagnostic and treatment times, including diagnostic waiting and reporting times	2.Within Trusts turnaround times (request to report) should be agreed between the clinical team, cancer services and diagnostics teams	2.Establishing a system of peer review amongst providers to assure the management of the cancer standards
	3.An effective radiology diagnostic network across GM is created to maximise the use of resources	3.Each Trust will establish a regular operational meeting to review performance against the standards	3.A review of access to diagnostic services that are not within the breach reallocation policy is undertaken
	4.Where one stop and straight-to-test options are appropriate, these should be adopted	4.Trusts should provide representation and monitor attendance at the Pathway Boards	4.Those cancers that have low referral numbers should be identified and agreed to allow a revised pathway to be explored
	5. Clinicians managing cancer services within organisations should be supported by a robust decision making and governance structure		5.Each Trust should have a regular education programme for clinicians and associated staff on the national cancer standards and their delivery

Table 2:

	1. What three things does your Trust do well	2. What three things does your Trust find most challenging
Summary for all provider Trusts	• Stop using the term ”2-week waits” and use “rapid assessment” • Set a target of 80% of referrals seen within 7 days • Introduction of straight to test (STT) in the colorectal pathway • Collaboration • Strong clinical management team (close working) • MDT Co-ordination and tracking combined person-represent the patient and emotionally engaged • Proactive and prepared to change – wide engagement • Good tracking, escalation and touch points • Engaged cancer board (which meets monthly) • Radiology good at upgrading cases • Functionality of cancer board – executive engagement to pathways • Cancer dashboard (via MDTs) role, includes clinical/quality metrics • Pathway improvement and innovation eg. Lung health checks and breast • Clinical engagement, communication and management support, all aware and engaged • Monthly cancer board meeting • Strategic focus on 7/365 • Robust PTLs – clinically led and micro-managed – fully engaged • Some high performing pathways • Good value for money to commissioners • Root cause analysis of breaches is undertaken to identify themes/actions/ share learning.	• Multi-site trust • PTL management and clinical engagement with partner organisation is separate processes • One approach across sties • Diagnostic capacity – radiology resource/capita lower • Acceptance of CARPs and oncology peripheral • Diagnostics at another Trust – no control of referral • Increased volume AND complexity of diagnostics and treatment pathway • Primary care engagement – having to triage in hospital’s activity • Patient engagement and patient awareness of reason for referral • Delay in obtaining Pathology results • Increased demand • Clinician engagement in managing PTLs – not engaged in struggling pathways • Heterogeneous pathways – diagnostics variation in what requested and when. Locking down slots for scan • TAT diagnostics with single handed practitioners • External diagnostics • Issues with patients crossing pathways • Repeat MDT discussions, proactive presumed decision • Diagnostic capacity and histology • OP capacity follow ups making getting news in harder • Complexity of radiotherapy and surgery • Re: review of pathology

3. Summary of Actions agreed by Provider Trusts:

- **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

- Relevant clinical input into PTL meetings the lead clinician and lead cancer nurse from both central and south sites would attend one PTL meeting as a learning action.

- TMO from both sites to meet together regularly.

- **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
- Review of management of PTLs and PTL meetings
- Explore obtaining patient consent at the local Trust before being seen at The Christie

The meeting closed with a summary of actions for GM Cancer, as led for the review to complete:

Actions **GM Cancer Team**	**Agreed action date**
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/COO meeting on Friday 12th January	12th January 2017
Full report summaries, all actions and agreed recommendation to be circulated for review	31st January 2018
Preliminary findings and summary paper ratification at the GM Cancer Board.	9th February 2018
Charge every Pathway Board with providing clear timed guidance on all pathways within the next 4 months	May 2018
Cancer Service Managers to be included in all clinical pathway revision projects	May 2018
GM Cancer will agree a framework for the governance and assurance of cancer standard management within organisations	May 2018
Establish a Radiology network within the next 6 months, to support the Trusts and pathways in maximise the use of resources	July 2018