

Haematological Oncology Pathway Board Annual Report 2013/14

Pathway Clinical Director: Mike Dennis
Pathway Manager: Melissa Wright

Executive summary

The establishment of the Haematological Oncology Manchester Cancer provider board has created a new opportunity for collaborative working across all the provider trusts. The initial working group has largely consisted of clinicians who have established the initial work plan for what will evolve to an expanded vision for a nationally leading service in relation to diagnosis and treatment of Haematological malignancy.

The challenges ahead

Development of a regional Specialist Integrated Haematological Diagnostic Service (SIHMDS)

This will require all trusts to support the development of a single collaborative model for Manchester Cancer as a whole. A service with a single provider that has overall financial and organisational managerial accountability and a single head of service, ideally all located on one site. It is envisaged this will draw upon current resource and capacity from a number of provider organisations which when integrated will provide a more efficient quality service.

Establishment of an integrated and robust system for online data capture, through MDT's, for a comprehensive Haematological cancer registry that can evaluate patient and disease outcomes

This will require all provider organisations agreeing upon utilisation of the same system collecting unified/comparative data.

Establishment of an online regional resource for a collaborative and integrated research portfolio

This will require active management of the online resource through Manchester Cancer which can integrate and link with all the trusts research and national resources.

Optimal access to diagnostic tissue biopsy facilities (surgery and image guided core biopsies)

More detailed evaluation is still required and on-going, new international guidelines and standards are anticipated that may have impact on service provision with respect to the frequency of needle core versus open tissue biopsy.

Introduction

2013/14 was a transitional year for cancer services in Greater Manchester and East Cheshire. The Greater Manchester and Cheshire Cancer Network ceased to exist in March 2013 when cancer networks nationally were amalgamated into strategic clinical networks as part of the NHS reorganisation. In Greater Manchester this coincided with the creation of Manchester Cancer, an integrated cancer system for Greater Manchester and East Cheshire.

Twenty Manchester Cancer Pathway Clinical Directors were appointed in late 2013 and took up their roles on 1st January 2014. They spent the first months in post forming their Pathway Boards, multi-professional clinical groups from across the region. These pathway Boards are now formed and most had their first meeting in April 2014.

As such, this is a transitional annual report. It outlines the current configuration of services, the progress in forming the Pathway Board, the data on outcomes and experience that the Board took into account when setting its objectives, and what those objectives are for 2014/15 and beyond. In July 2015 every Manchester Cancer Pathway Board will publish a full annual report, outlining the work of its first full year and its progress against those objectives.

This annual report is designed to:

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

1. General overview

Nationally, the Improving Outcomes Guidance in Haemato-Oncology (2003) is the key document that should be used to develop services for patients with haematological malignancies. It recognised the distinctive difference between the diseases within this cancer group and how this should be reflected in the organisation of services and the specialties involved. Additionally haemato- oncology clinical pathways also feed into the national service specification for Haematopoietic Stem Cell Transplantations for adults.

Data on incidence and mortality for haematological malignancies are difficult to analyse in a meaningful way at a sub-national level as many of the malignancies are rare. They are a very diverse group of diseases affecting people across the whole life course, but their greatest incidence is amongst the elderly. The prognosis and responsiveness to treatment also varies widely.

Haematological malignancies accounted for 8.3% of all malignant disease (excluding non-melanoma skin cancer) diagnosed in the years 2001-2008. During this time, age standardised incidence rates for all haematological malignancies has increased from 38.5 to 42.7 for men and 25.6 to 29.2 for women per 100,000 of the population. Conversely, mortality rates have fallen from 17.8 – 16.2 for men and from 11.4 to 10 for women per 100,000 of the population.

For both men and women Non-Hodgkin Lymphoma was disease group with the highest number of new cases between 2006 -2008.

Table 1 Age-standardised incidence rates for persons for haematological malignancies diagnosed in 2006 -2009 by diagnostic group

Site	Incidence		Mortality	
	Cases	ASR	Deaths	ASR
Acute Lymphoblastic Leukaemia	500	1.3	217	0.4
Acute Myeloid Leukaemia	2,231	3.4	1,818	2.6
Chronic Lymphocytic Leukaemia	2,381	3.5	938	1.2
Chronic Myeloid Leukaemia	544	0.9	201	0.3
Hodgkin Disease	1,457	2.7	269	0.4
Non-Hodgkin Lymphoma	9,691	15.2	3,735	5.2
Myeloma	3,736	5.5	2,212	3.0
Other	1,521	2.3	273	0.4
All Haematological Malignancies	22,151	34.7	9,663	13.4

2. Background to the pathway/cross-cutting area

The Haemato-Oncology network group was of multi-professional membership and was chaired by Dr Jim Cavet – Consultant Haematologist at The Christie NHS Foundation Trust. The core of this group was drawn from MDT lead clinicians from each specialist and local team and clinical support services involved in tumour management along the patient care pathway. Its purpose was to ensure that services for patients with suspected or diagnosed haematology cancers are being delivered in accordance with NICE Improving Outcomes Guidance and Peer Review Cancer Quality Measures.

Cancer Networks played a key role in reconfiguring cancer services since they were established in 2000, following the first cancer plan, with the result that both survival figures and patient experience have improved. The last meeting of the Haemato-Oncology network group was June 2013. It is clear from the most recent Peer Review Self-Assessment report that capturing data on performance across the network has been difficult and that has resulted in a lack of clarity around Cancer Wait Time breaches. It also highlights that there has been issues with staging data due to the denominator being inaccurate. Significant achievements for the network include prompt access to level 3 and 4 transplant services, despite the expansion of transplant activity.

Their Peer Review report also recognises the challenge to the workload of single-handled centres with lone consultants and MDT configuration continues to be evaluated by the Haemato-Oncology Pathway Board.

The focus of the most recent Haemato-Oncology work programme is identified in its constitution and included below:

Table2. IOG Implementation Action Plan

Objective	Date achieved	Current Progress
Strengthen Core MDT membership in all localities	2012	All sector MDT's are quorate and have >500,000 population size
Acute Leukaemia and Aggressive Lymphoma facilities enhanced to standard in 6 locations	2012	AL/High-grade NHL facilities established in Bolton, Salford, Pennine, Central and the Christie
Establish a Haematological Malignancy Diagnostic Service (HMDS)	On-going, Phase I-II 2011-12	Phase I HMDS initially implemented, but understaffing led to external referrals to Leeds HMDS
JACIE accredited transplant centres established	Tri-annual re-accreditation	Central and the Christie accredited

3. Configuration of services

Manchester Cancer covers the area of Greater Manchester and East Cheshire Cancer and covers a population of just over 3 million and is served by the following organisations:

North West Sector

Royal Bolton Hospital NHS Foundation Trust
Salford Royal NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Trust

North East Sector

Pennine Acute Hospitals NHS Trust

Central Sector

Central Manchester University Hospitals NHS Foundation Trust
Tameside Acute NHS Foundation Trust

South Sector

The Christie Hospital NHS Foundation Trust
East Cheshire NHS Trust
Stockport Foundation Trust
University Hospital of South Manchester NHS Foundation Trust

Local Haemato-Oncology Teams

All local MDTs within this sector will deal with Leukaemia (Acute and Chronic) & MPD, Lymphoma and Myeloma. These teams will carry out the diagnostic process and treatment for symptomatic patients from their own catchment area. Local teams will refer patients to the Christie hospital or to their local radiotherapy unit for radiotherapy and to specialist level 2,3 and 4 centres via their MDT catchment for chemotherapy/stem cell transplantation/trials if unable to provide locally.

Specialist Haemato-Oncology Teams

There are four Trusts providing additional specialist level treatment. Level 2 Trusts support specialist work in Acute Leukaemia and Level 3 & 4 provides specialist treatment for Stem Cell Transplantation.

Table 3. Specialist Haemato-Oncology Team configuration

Specialist Haemato-Oncology Cancer Team	SMT Lead Clinician	Referring MDT's
The Christie NHS Foundation Trust Levels; 2,3,4	Dr Mike Dennis	East Cheshire, the Christie, Stockport, UHSM
Central Manchester NHS Foundation Trust Levels; 2,3,4	Dr Fiona Dignum	Central, Tameside
Salford Royal NHS Foundation Trust Level 2	Dr Simon Joweitt	Bolton, Salford WWL
Pennine Acute NHS Trust Level 2	Dr Hayley Greenfield	Pennine

4. Clinical guidelines

The Haematological Oncology Pathway Board has only been in place since April 2014 and has not yet had the opportunity to review its clinical guidelines and patient pathways. As such, the guidelines created by the previous cancer network group have been adopted until such time as they can be reviewed and updated in the coming year.

All of the relevant documentation has been migrated from the old cancer network website and can now be found at www.manchestercancer.org/services/haemato-oncology

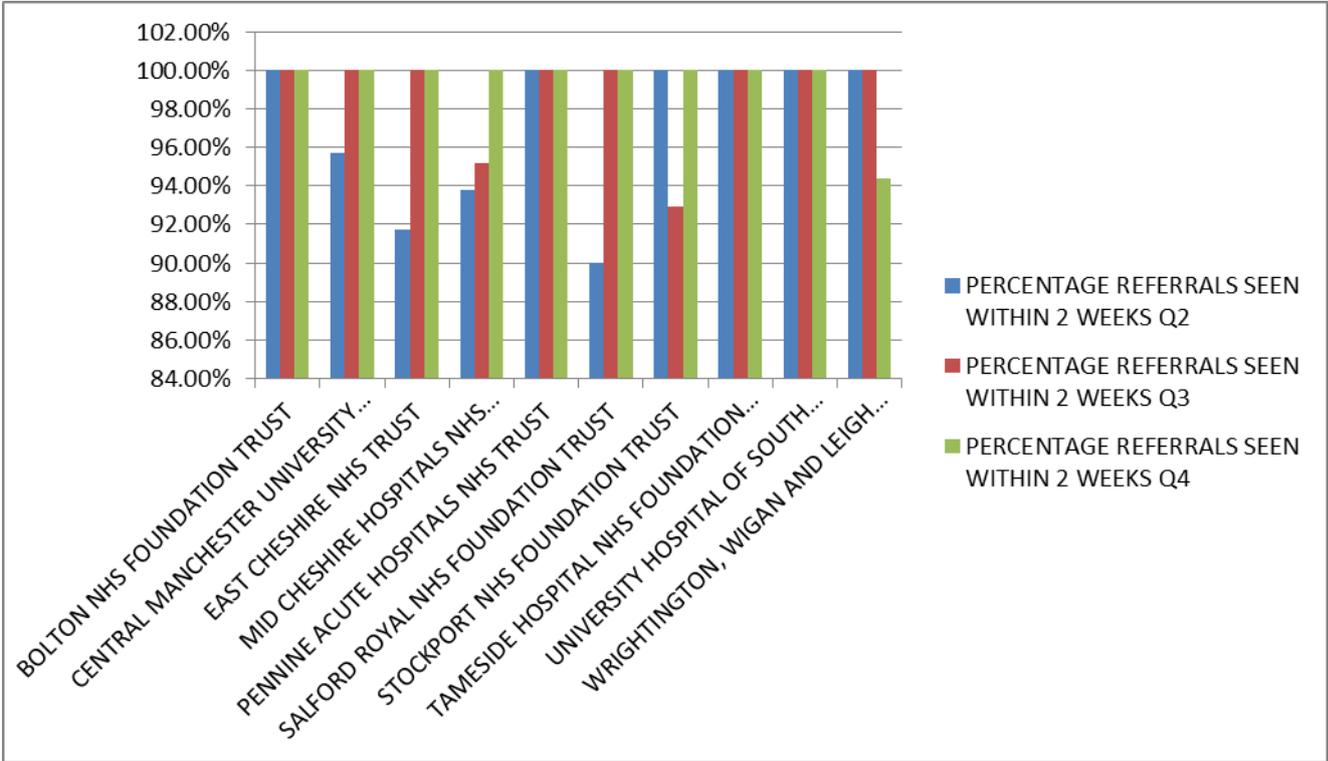
A full list of active current guidelines and their renewal dates will be produced for the next annual report of July 2015.

5. Clinical information and outcomes

As stated earlier within this report, the nature of this disease group, including the rare occurrence of some haematological malignancies has resulted in limited access to certain clinical outcomes data.

Clinical information and outcomes was discussed at the first Pathway Board meeting and members felt that a mapping of routinely collected data within other regions would be useful for this disease group. Additionally performance data linked to targets around the 2WW, 31 and 62 day pathways would be useful. At present, cancer waiting times data for both 31 and 62 day treatment pathways for all haematological malignancies cannot be accessed via the NHS England website and locally, this is not available through a central source.

Figure 1. Greater Manchester and Cheshire 2WW data for 2013-14 Q3 & Q4

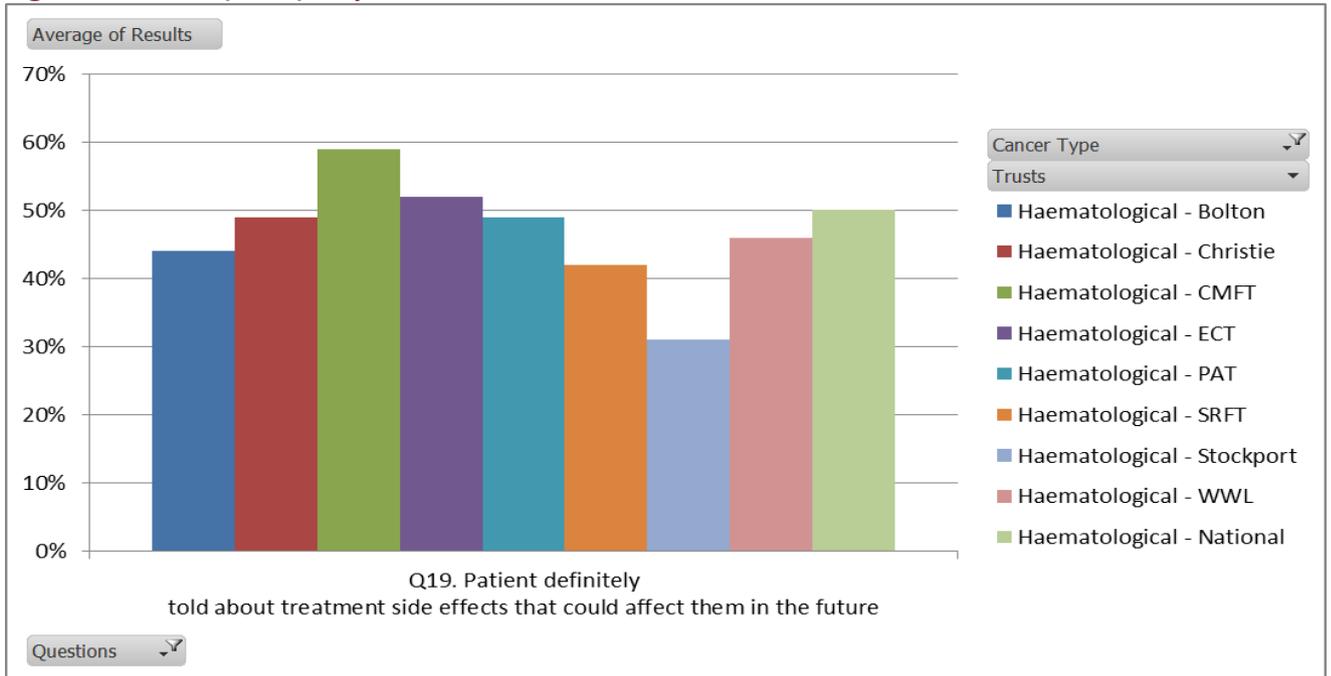


6. Patient experience

The Haemato-Oncology Pathway Board reviewed the 2013 results of the National Cancer Patient Experience Survey (NCPES) at the meeting held in June. It was recognised that both Tameside and UHSM were not included in the analysis as their numbers were too small for reliable analysis. In addition to Bolton achieving results within the top 10 nationally, all Trusts had performed reasonably well. There were some questions where the national

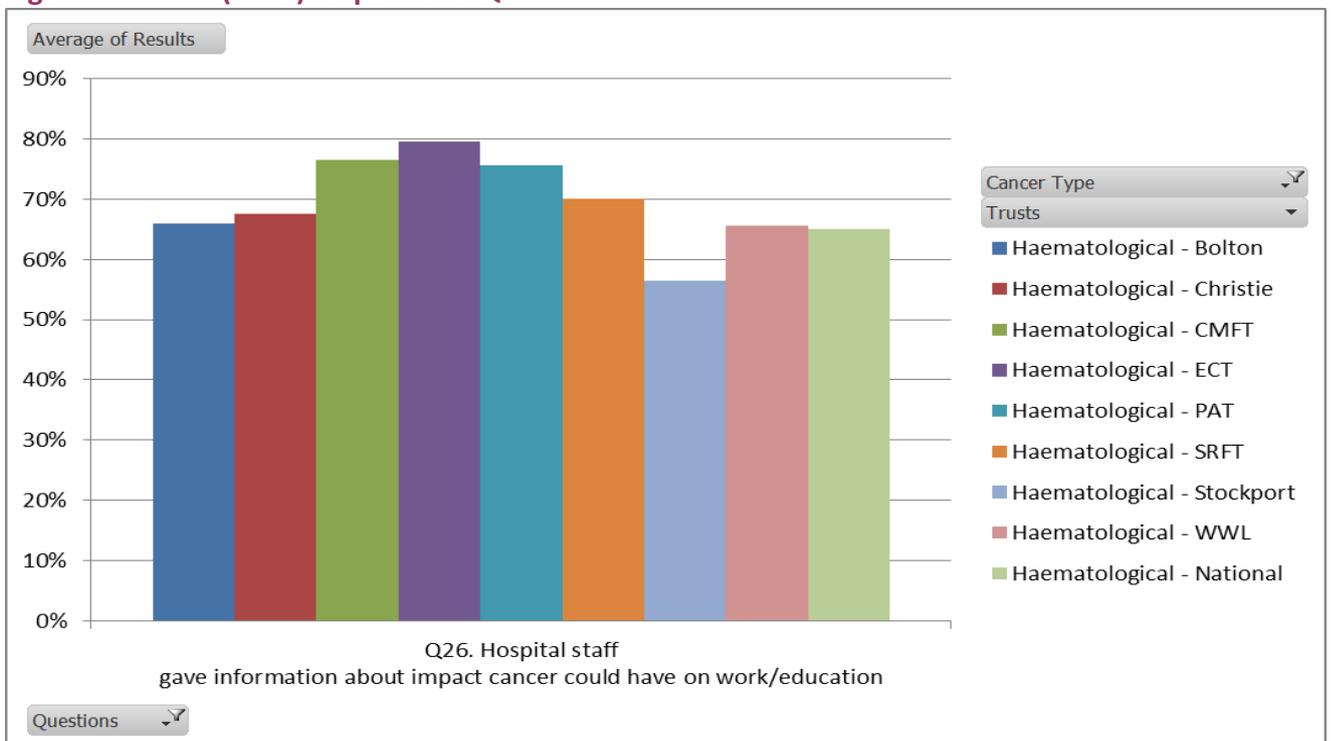
response was poor and this was reflected locally within Greater Manchester. An example of this is patients being told about treatment side effects that could affect them in the future.

Figure 2. NCPES (2013) response to Q19



For some questions, the national response for haematological cancers was fairly positive and Greater Manchester achieved similar or higher responses, one such question focused on the impact of cancer on patients’ work and education.

Figure 3. NCPES (2013) response to Q26



There were questions where some Trusts did significantly better than other - one such example was whether taking part in cancer research was discussed with the patient.

Comprehensively, it is clear from question 70 that most patients had a positive experience of care.

Figure 4. NCPES (2013) response to Q30

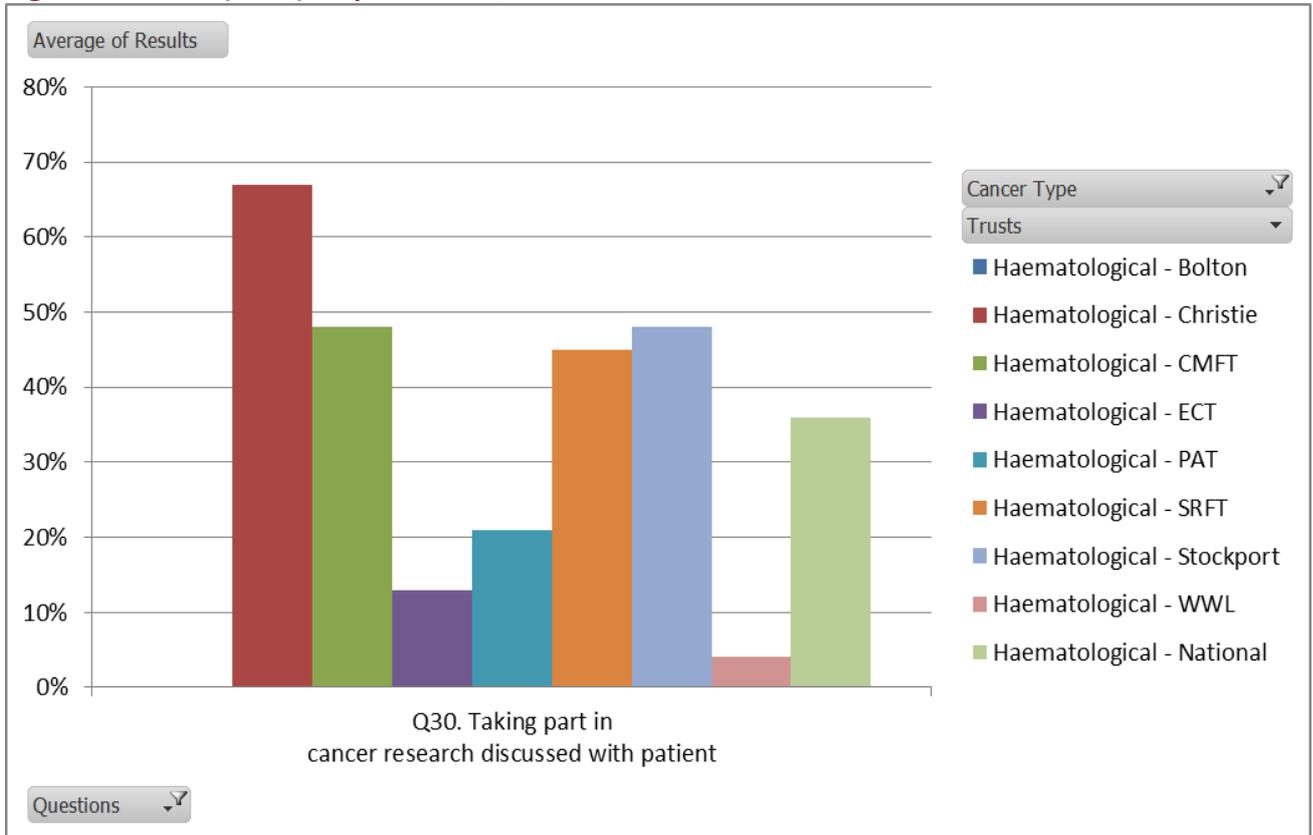
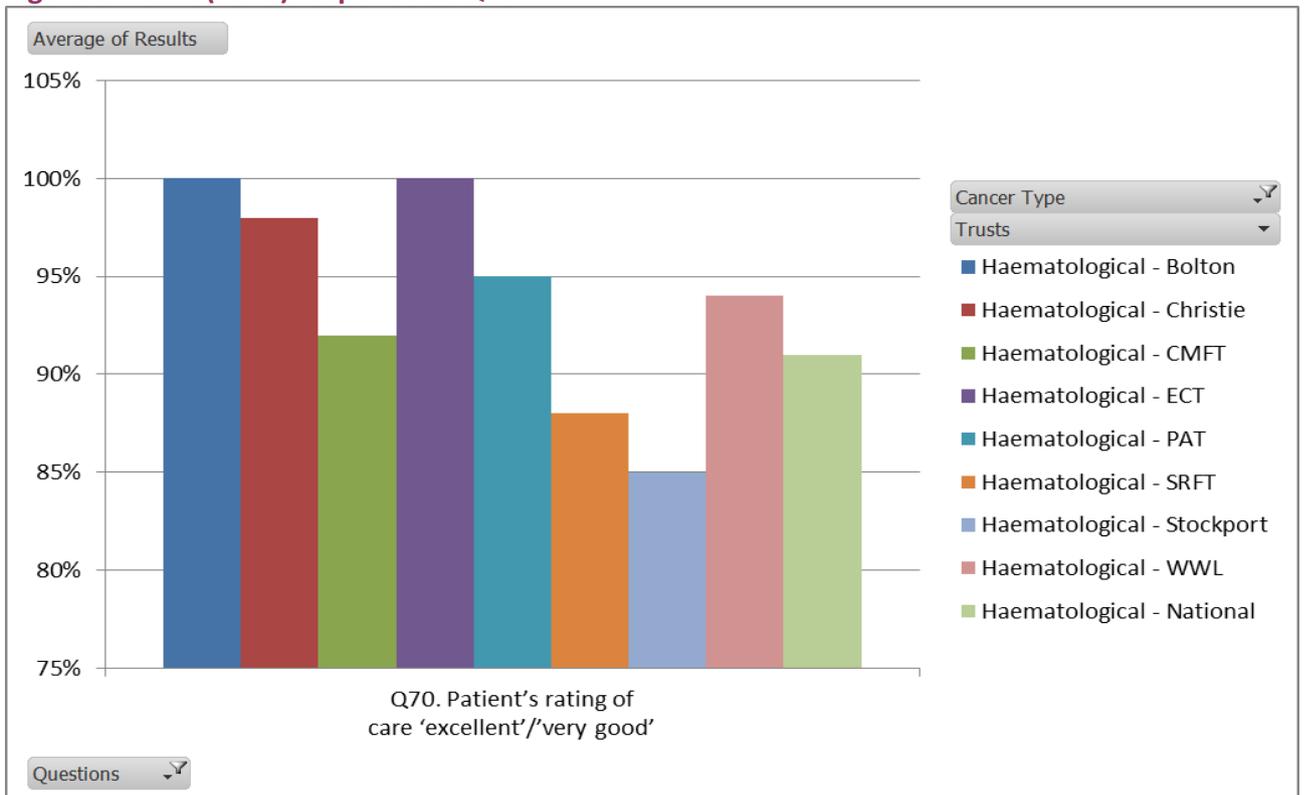


Figure 5 NCPES(2013) response to Q70



7. Research and clinical trials

Research activity is a high priority for the Haematological Oncology Pathway Board and this will be a regular agenda item at the Pathway Board. Data from the NIHR Clinical Research Network identifies that in 2013-14 Greater Manchester exceeded its Research Network target of recruiting 178 patients into portfolio cancer/pre-malignant haematology and lymphoma studies and in fact recruited 378 overall. The headline report provided by the network was discussed at the meeting in June and it was agreed that a more collegiate approach to developing the research portfolio would be useful and the Pathway Board would be used to facilitate this. It was agreed that the Research Lead for the Board would work with the Research Network Manager to develop a reporting process that clearly defines the research opportunities available across the region.

In addition, the NCPES (2013) indicated that within Greater Manchester, although more patients had seen information regarding cancer research within most Trusts where data was available fewer patients had taken part in cancer research.

8. Innovation in clinical practice

In the North West there has been an increase in transplant activity, in particular umbilical cord transplantation. Along with this there has also been the development of remote follow-up by the lymphoma team and the management of local follow-up of long-term survivors by the ADAPT team.

9. The Pathway Board

9.1. Formation of the Board

The principle of Manchester Cancer Pathway Boards is that they should be professionally and institutionally representative, yet small and manageable in size. To help Pathway Clinical Directors form institutionally representative Boards the Manchester Cancer central team sought nominations from trusts for their representative(s) on 16 of the 20 Pathway Boards. Nominations were not sought for Children's, Sarcoma, Palliative Care and Early Diagnosis as alternative arrangements were necessary in these areas.

For each Pathway Board trusts were asked to provide up to three nominations from a range of professions from which the trust representative(s) could be chosen. The team asked that nominations included a brief statement of the individual's suitability for membership of the relevant Pathway Board.

Nominations were passed to Pathway Clinical Directors who took them into account when forming their Boards. Trusts were informed during this process that Directors would not be obliged to accept all trust nominations but that, if a Pathway Clinical Director wished to

appoint a trust representative that had not been nominated by their organisation, then this would be discussed with the Trust Cancer Clinical Lead.

9.2. Membership

The membership of the Pathway Board is attached below however it still requires patient representation. Patient engagement is a high priority for the Haemato-Oncology Pathway Board. At the first meeting in April strategies for engaging patient representatives to the board were discussed and following this, 3 potential patients had registered their interest. In conjunction with this, a patient advocate has been recruited to support patients in their contribution. A patient voice will add a valued perspective to the Pathway Board and, due to the rare occurrence of some of the haematological malignancies, building a picture of how potential changes to certain pathway may be viewed by patients will be important.

The Pathway Board membership is small in comparison to other Pathways but it has been agreed that there will be named representatives aligned to the group e.g. to lead on early diagnosis or radiotherapy, but they would not necessarily attend all meetings.

Name	Role	Haematological Oncology Pathway Representation
Dr Mike Dennis	Consultant Haematologist	Chair
Bolton		
Dr Clare Barnes	Consultant Haematologist	Trust Representative
Christie		
Jo Tomlins	Nurse clinician	Nursing and trust representative
CMFT		
Dr Eleni Tholouli	Consultant Haematologist	Trust Representative
East Cheshire		
Dr John Hudson	Consultant Haematologist	Trust Representative
Pennine		
Dr Hayley Greenfield	Consultant Haematologist	Trust Representative
Salford Royal		
Dr Simon Jowitt	Consultant Haematologist	Trust Representative
Stockport		
Dr Montaser Haj	Consultant Haematologist	Trust Representative
Tameside		
Dr Hussein Baden	Consultant Haematologist	Trust Representative
UHSM		
Dr Simon Watt	Consultant Haematologist	Trust Representative
WWL		
Dr Hitesh Patel	Consultant Haematologist	Trust Representative

9.3. Meetings

To date there have been two Pathway Board meetings and meetings are scheduled to take place every two months. The record of attendance and approved minutes are included in the appendix.

10. Progress and challenges to date

Although the Pathway Board model of working is fairly new, there has been significant buy-in to this method of improving services. Work has already taken place to review the MDT structure (appendix 5) and from this it is clear that this is working well.

The challenges identified include the non-compliance of peer review concerns of lymphoma. There are also concerns regarding diagnostic activity and the turnaround times for this disease group, which have been reflected within the objectives of the action plan.

11. Vision and objectives

Within Manchester Cancer Haematology currently services run separately by each individual Trust. The vision is the development of an integrated service across the sector. This will allow for a more integrated model of care delivery. The annual plan, which can be found in the appendix, identifies the work that will be undertaken in the next year.

12. Appendix 1 – Pathway Board Terms of Reference

**Haematological Oncology Cancer Pathway Board
Terms of Reference**

These terms of reference were agreed on 10th April 2014 by Mike Dennis, Pathway Clinical Director for Haematological Oncology Cancer, and Mr David Shackley, Medical Director of Greater Manchester Cancer Services, on behalf of the Greater Manchester Cancer Services Provider Board. The terms of reference will be subject to future review.

1. The Pathway Board

The Haematological Oncology Cancer Pathway Board is a cancer care specific board with responsibility to improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire (a catchment population of 3.2 million). This area is synonymous with the old Greater Manchester and Cheshire Cancer Network area.

The Pathway Board is led by a Pathway Clinical Director and is formed of a multidisciplinary team of clinicians and other staff from all of hospital trusts that are involved in the delivery of Haematological Oncology cancer care in Greater Manchester. The Pathway Board also has membership and active participation from primary care and patients representatives.

The Haematological Oncology Cancer Pathway Board reports into and is ultimately governed and held to account by the Greater Manchester Cancer Services Provider Board.

2. Greater Manchester Cancer Services Provider Board

The Greater Manchester Cancer Services Provider Board is responsible for the service and clinical delivery arm of Manchester Cancer, Greater Manchester's integrated cancer system. Manchester Cancer has two other arms: research and education (see appendix for the structure of Manchester Cancer).

The Provider Board is independently chaired and consists of the Chief Executive Officers of the ten acute hospital trusts in the Greater Manchester area:

- Bolton NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- East Cheshire NHS Trust
- Pennine Acute NHS Trust
- Salford Royal NHS Foundation Trust
- Stockport NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust
- The Christie NHS Foundation Trust
- University Hospital of South Manchester NHS Foundation Trust;
- Wroughtington, Wigan and Leigh NHS Foundation Trust;

The Provider Board regularly invites representatives of commissioners, the Strategic Clinical Network, and Manchester Cancer to its meetings.

3. Purpose of the Pathway Board

The purpose of the Pathway Board is to improve cancer care for patients on the Greater Manchester Haematological Oncology cancer pathway. Specifically, the Pathway Board aims to save more lives, put patients at the centre of care, and improve patient experience. The Board will represent the interests of local people with cancer, respecting their wider needs and concerns. It is the primary source of clinical opinion on this pathway for the Greater Manchester Cancer Services Provider Board and Greater Manchester's cancer commissioners.

The Pathway Board will gain a robust understanding of the key opportunities to improve outcomes and experience by gathering and reviewing intelligence about the Haematological Oncology cancer pathway. It will ensure that objectives are set, with a supporting work programme that drives improvements in clinical care and patient experience.

The Pathway Board will also promote equality of access, choice and quality of care for all patients within Greater Manchester, irrespective of their individual circumstances. The Board will also work with cancer commissioners to provide expert opinion on the design of any commissioning pathways, metrics and specifications.

4. Role of the Pathway Board

The role of the Haematological Oncology Cancer Pathway Board is to:

Represent the Greater Manchester Cancer Services professional and patient community for Haematological Oncology cancer.

Identify specific opportunities for improving outcomes and patient experience and convert these into agreed objectives and a prioritised programme of work.

Gain approval from Greater Manchester's cancer commissioners and the Greater Manchester Cancer Services Provider Board for the programme of work and provide regular reporting on progress.

Design and implement new services for patients where these progress the objectives of commissioners and Greater Manchester Cancer Services, can be resourced, and have been shown to provide improvements in outcomes that matter to patients.

Ensure that diagnosis and treatment guidelines are agreed and followed by all teams in provider trusts, and are annually reviewed.

Ensure that all providers working within the pathway collect the pathway dataset measures to a high standard of data quality and that this data is shared transparently amongst the Pathway Board and beyond.

Promote and develop research and innovation in the pathway, and have agreed objectives in this area.

Monitor performance and improvements in outcomes and patient experience via a pathway scorecard, understanding variation to identify areas for action.

Escalate any clinical concerns through provider trusts.

Highlight any key issues that cannot be resolved within the Pathway Board itself to the Medical Director of Greater Manchester Cancer Services for assistance.

Ensure that decisions, work programmes, and scorecards involve clearly demonstrable patient participation.

Share best practices with other Pathway Boards within Greater Manchester Cancer Services.

Contribute to cross-cutting initiatives (e.g. work streams in living with and beyond cancer and early diagnosis).

Discuss opportunities for improved education and training related to the pathway and implement new educational initiatives.

Develop an annual report of outcomes and patient experience, including an overview of progress, difficulties, peer review data and all relevant key documentation. This report will be published in July of each year and will be the key document for circulation to the Provider Board. A template for this report is available so that all Pathway Boards complete the report in a similar manner.

5. Membership principles

All member organisations of Greater Manchester Cancer Services will have at least one representative on the Pathway Board unless they do not wish to be represented.

Provider trusts not part of Greater Manchester Cancer Services can be represented on the Pathway Board if they have links to the Greater Manchester Haematological Oncology cancer pathway.

All specialties and professions involved in the delivery of the pathway will be represented.

The Board will have at least one patient or carer representative within its membership

One professional member of the Pathway Board will act as a Patient Advocate, offering support to the patient and carer representative(s).

The Board will have named leads for:

- Pathology
- Radiology
- Stem cell transplantation
- Surgery
- Teenagers and young adults
- Specialist nursing
- Living with and beyond cancer ('survivorship')
- Research
- Data collection (clinical outcomes/experience and research input).

It is possible for an individual to hold more than one of these posts. The Pathway Clinical Director is responsible for their fair appointment and holding them to account.

These named leads will link with wider Greater Manchester Cancer Services Boards for these areas where they exist.

All members will be expected to attend regular meetings of the Pathway Board to ensure consistency of discussions and decision-making (meeting dates for the whole year will be set annually to allow members to make arrangements for their attendance).

A register of attendance will be kept: members should aim to attend at least 5 of the 6 meetings annually and an individual's membership of the Pathway Board will be reviewed in the event of frequent non-attendance.

Each member will have a named deputy who will attend on the rare occasions that the member of the Board cannot.

6. Frequency of meetings

The Haematological Oncology Cancer Pathway Board will meet every two months.

7. Quorum

Quorum will be the Pathway Clinical Director plus five members of the Pathway Board or their named deputies.

8. Communication and engagement

Accurate representative minutes will be taken at all meetings and these will be circulated and then validated at the next meeting of the Board.

All minutes, circulated papers and associated data outputs will be archived and stored by the Pathway Clinical Director and relevant Pathway Manager.

The Pathway Board will design, organise and host at least one open meeting per year for the wider clinical community and local people. This meeting or meetings will include:

- An annual engagement event to account for its progress against its work programme objectives and to obtain input and feedback from the local professional community
- An annual educational event for wider pathway professionals and interested others to allow new developments and learning to be disseminated across the system

Representatives from all sections of the Greater Manchester Cancer Services professional body will be invited to these events, as well as patient and public representatives and voluntary sector partners.

An annual report will be created and circulated to the Medical Director of the Greater Manchester Cancer Services Provider Board by 31st July of each calendar year.

The agendas, minutes and work programmes of the Pathway Board, as well as copies of papers from educational and engagement events, will be made available to all in an open and transparent manner through the Greater Manchester Cancer Services website once this has been developed.

9. Administrative support

Administrative support will be provided by the relevant Pathway Manager with the support of the Greater Manchester Cancer Services core team. Over the course of a year, an average of one day per week administrative support will be provided.

13. Appendix 2 – Pathway Board meeting attendance

Include here a table outlining the attendance at each Board meeting and a summary of each member’s attendance for the whole year.

ATTENDANCE - PATHWAY BOARD MEETING

NAME	ROLE	TRUST	10th April 2014	26th June 2014
Clare Barnes	Consultant Haematologist	Bolton		
Jo Tomlins	CNS	Christie		deputy attended
Eleni Thoulouli	Consultant Haematologist	CMFT		
John Hudson	Consultant Haematologist	East Cheshire		
Hayley Greenfield	Consultant Haematologist	Pennine	deputy attended	
Simon Jowett	consultant Haematologist	SRFT		
Dr Montaser Haj	Consultant Haematologist	Stockport		
Hussein Baden	Consultant Haematologist	Tameside		
Simon Watt	Consultant Haematologist	UHSM		
Hitesh Patel	Consultant Haematologist	WWL		

14. Appendix 3 –Approved Pathway Board minutes to 31st July 2014

Haematological Oncology Pathway Board

Thursday 10th April 2014, 3pm – 5pm, HTU Seminar Room, The Christie

Attendance	
Name	Pathway Representation
Mike Dennis	Chair
Clare Barnes	Bolton Representative
Jo Tomlins	Nursing and Christie Representative
Eleni Tholouli	CMFT Representative
Catherine Wardley	Pennine Representative (deputy)
Simon Jowitt	Salford Representative
Hitesh Patel	WWL Representative
Melissa Wright	Pathway Board Manager
Apologies	
Name	
John Hudson	East Cheshire Trust Representative
Montaser Haj	Stockport Trust Representative
Hussein Baden	Tameside Trust Representative

Agenda Item	Action
1. Welcome and Introductions MD welcomed everyone to the first Pathway Board meeting.	
2. Apologies Apologies were noted.	
3. Background to Manchester Cancer and Pathway Boards MW gave a short presentation on the background to Manchester Cancer and its ambition to reduce the excess premature deaths from cancer in Greater Manchester and to support the growing number of patients that will be living with and beyond cancer.	

<p>The focus of Pathway Boards will be on all areas of the patient pathway, not just those that take place within acute hospitals. This will be done through the collection and analysis of data, which will support the identification of opportunities to change and improve current pathway models. This work will be documented in an annual work plan, which will form part of a three-year plan. MW also provided information on the Manchester Provider Board which is made up of the 10 CEO's of the acute Trusts in Manchester along with representatives from the Strategic Clinical Network, patients and local commissioners.</p> <p>ET asked whether The Haematological Oncology Pathway Board should include a wider representation of all areas of the pathway. MD felt that the current membership should broadly remain although a CNS (or other colleague) should be recruited to act as a deputy for each representative, who would inevitably be required to attend the board with some regularity. Additional members were also discussed as part of the board terms of reference. The nursing lead would be responsible to coordinate active contribution from nursing colleagues.</p> <p>ACTION The Board will nominate representatives from other clinical disciplines to engage with the Pathway Board as and when necessary</p>	<p>ALL</p>
<p>4. Terms of Reference</p> <p>MD explained that each Pathway Board required a Terms of Reference which has already been amended to fit with the specifics of this pathway. It also required named leads for certain pathway areas. The following named leads were proposed at the meeting.</p> <p>HG – Teenagers and Young Adults JT – Specialist Nursing ET – Stem Cell Transplantation</p> <p>ET thought that it would be useful to look at delays in accessing surgery and any impact this has on on-going treatment.</p> <p>The task of how to secure a patient representative was also discussed. ET had a patient whom she felt would be suitable for the Board, but who may not be able to dedicate the time at present. MW explained that all patients' representatives will be offered bespoke training on supporting Pathway Boards from Macmillan. It was agreed that 2 patient representatives should be sought for the Board. The terms of reference as tabled were agreed by the board.</p> <p>ACTION MD to email members of the Board to seek nominations for named leads for the pathway areas</p> <p>All members of the Board to nominate suitable patients and forward contact details to MW</p> <p>MW to ensure patient representatives are enrolled onto Macmillan patient event</p>	<p>MD</p> <p>All</p> <p>MW</p>
<p>5. Establishing a priority work plan</p> <p>Several areas of the pathway were identified and agreed by the board for priority inclusion into the work plan:</p> <p>Specialist integrated Haematological Malignancy Diagnostic Service (SIHMDS) – The process for</p>	

<p>this was not consistent across all Trusts. The lack of HMDS provision within Manchester was identified as a top priority which should be reviewed with immediacy.</p> <p>Surgical access for Lump excision – It was felt that the wait for surgical intervention for lumps was delaying on-going treatment for patients and would be having impact on patient outcomes.</p> <p>Clinical Outcomes – The members thought it would be useful to look at 2WW referrals to identify whether there is a need for GP education as well as to identify where breaches happen.</p> <p>MDT configuration</p> <p>ACTION: Work plan areas; Diagnostics; Lumps; Clinical Outcomes; MDT configuration</p>	<p>MW</p>
<p>6. Clinical Outcomes</p> <p>The meeting discussed the range of data that could be brought to the Pathway Board and the development of additional datasets to support the understanding of clinical outcomes. Through the MDT's each MDT lead has local data collection e.g. SJ started a database local to Salford but this does not include survival data. Pennine and CMFT both use Somerset. MD would also like to look at National Patient Survey data which is collected on a yearly basis at Trust level and split by disease groups. SJ thought it would be useful to identify what data is routinely collected on Haematological Oncology within other regions.</p> <p>ACTION MD to investigate the progress nationally with regard to data set collection</p> <p>Data from the national Patient Survey Data, 2WW, 31/62 CWT to be brought to the next meeting</p>	<p>MD</p> <p>MW</p>
<p>7. Peer review 2014</p> <p>MD identified how the Pathway Board will support the work of the peer review process and indicated that there may be some diagnostic compliance issues for the network later this year as a consequence of the lack of a SIHMDS.</p>	
<p>8. MDT Structure</p> <p>MD asked about the current configuration of MDT's and whether these were optimal or needed evaluation. ET thought that there wasn't enough radiation oncology support and CW felt this was similar for Pennine. MD suggested that the challenge in getting specific clinical input may present a case for reducing the numbers of MDT's. SJ thought that this would increase the time commitment of these meetings which may not be feasible. ET felt radiation oncologists should be available on a monthly basis for MDT's with rare and difficult cases. MD thought it would be useful to review how all specialties input into MDT's.</p> <p>ACTION: MD to coordinate review of MDT configuration and deficiencies</p>	<p>MD</p>
<p>9. Diagnostic Pathways/SIHMDS</p> <p>These were discussed earlier in the meeting</p>	
<p>10. Research portfolio</p> <p>MD felt it would be important to evaluate who is undertaking which trial and where these are based with a view to having a Manchester Cancer coordinated/collaborative portfolio. The impact of travel in regards to accessing clinical trials was also noted. MW explained that Cancer</p>	

<p>Research Networks will no longer exist in their current form but will be merging with the Clinical Research Networks. There will be six divisions to these networks and cancer will be in the first division. The value of previous research reports to the network group were noted.</p> <p>ACTION: Manchester cancer research report for Haematological oncology to be tabled at all subsequent boards</p>	<p>MW</p>
<p>11. Clinical Guidelines MD highlighted that most of the clinical guidelines are due for review. SJ thought it would be useful to place all relevant guidelines onto the website that will be hosted by Manchester Cancer Services. MW explained that work is underway to create the website for Manchester Cancer and a further update on its development will be given at the next meeting.</p> <p>ACTION: MD to talk to Paddy Carrington regarding his role in coordinating the updating of guidelines</p>	<p>MD</p>
<p>12. Educational programme It was agreed that this would be undertaken in conjunction with the North West Haematology Education Programme.</p>	
<p>13. Clinical Concerns These were discussed earlier in the meeting</p>	
<p>14. Patient Experience This was discussed earlier in the meeting</p>	
<p>15. A.O.B. There was no other business</p>	
<p>16. Date of next meeting Following a request from HG it was agreed that the meeting dates would be moved to the fourth Thursday of every other month. The previous electronic invites would be replaced with the new dates. The offer of rotating the meeting to alternative sites was made, however members agreed that they were happy to continue meeting at The Christie.</p> <p>ACTION: Updated dates and venue details to be circulated for 2014</p> <p>Date of next meeting - Thursday 26th June, 3 pm – 5 pm, The Christie (HTU seminar room)</p>	<p>MW</p>

15. Appendix 4 – Pathway Board Annual Plan 2014/15

Haematological Oncology Pathway Board Annual Plan 2014-15

Pathway Clinical Director:	Mike Dennis
Pathway Board Members:	 Greater_Manchester _Cancer_Services_Ha
Pathway Manager:	Melissa Wright
Date agreed by Pathway Board:	
Date agreed by Medical Director:	
Review date:	

Summary of objectives

The Pathway Board should agree three to five objectives. Objectives should be specific, measurable, achievable, relevant and time-bound. The timeline for achievement of objectives can extend beyond 2014/15 but the Pathway Board should be clear on what progress will be made within the year.

The agreed objectives should be summarised here and expanded upon in the following pages. The summary should also outline the alignment of these objectives to those of the Manchester Cancer Provider Board outlined in the appendix.

Manchester Cancer

No	Objective	Alignment with Provider Board objectives
1	Diagnostics Development of a regional Specialist Integrated Haematological Malignancy Diagnostic Service	Patient EXPERIENCE
2	Clinical Outcomes Further evaluation of uniform data capture which will allow collection of data to robustly assess patient outcomes, to include optimal utilisation of evolving IT platforms.	1-year SURVIVAL
3	Research and Innovation Develop a Manchester Cancer trials resource so that all MDT's can access real time information on potential studies.	RESEARCH and INNOVATION
4	Treatment To improve surgical access for lump excision	Patient EXPERIENCE

Objective 1: Development of a regional Specialist Integrated Haematological Diagnostic Service

Objective:	To identify the opportunity to develop a regional HMDS service.
Rationale:	<ul style="list-style-type: none"> • To improve diagnostic accuracy in haematological malignancies • Integration of regional diagnostic expertise • More efficient delivery of diagnostic service turnaround times and financial • Peer review compliance issue
By (date):	August 2017
Board measure(s):	<ul style="list-style-type: none"> • 2WW • Audit of lymphoma breaches
Risks to success:	<ul style="list-style-type: none"> • Commissioner support • User/stakeholder support • Strategy and investment from an individual Trust
Support required:	Manchester Cancer need to support the decision made by the Pathway Board and communicate this with commissioners

The programme of work through which the Pathway Board will achieve the objective should be outlined below. This can take whatever form the Pathway Board considers appropriate. Two suggested formats are provided.

Work programme		
Action	Resp.	By (date)
Set up stakeholder meeting	MD	August 2014
Pathway Board to agree a Trust to lead and recommendation paper	PB	December 2014
Promote importance of this issue to Manchester Cancer and commissioners	MD/MW	January 2015
Proposal presented at Manchester Cancer Provider Board	MD	February 2015

Work programme

Manchester Cancer

Task	Resp.								
		May-June	July-Aug	Sept-Oct	Nov-Dec	Jan-Feb	Mar-Apr	May-June	July-Aug
Set up stakeholder meeting	MD								
Pathway Board to agree a Trust to lead and recommendation paper	PB								
Promote importance of this issue to Manchester Cancer and commissioners	MD/MW								
Proposal presented at Manchester Cancer Provider Board	MD								

Objective 2: To evaluate clinical outcomes

Objective:	<ul style="list-style-type: none"> To further evaluate uniform data capture which will support collection of data to robustly assess patient outcomes To include optimal utilisation of evolving IT platforms.
Rationale:	To establish baseline clinical outcomes that can benchmark the service across different organisations and facilitate improvement in outcomes.
By (date):	July 2015
Board measure(s):	<ul style="list-style-type: none"> Annual report from each MDT Numbers of patients discussed and patients in clinical trials 3-year survival rates Audit of complications of chemotherapy SACT data
Risks to success:	<ul style="list-style-type: none"> Each provider Trust being willing to invest in new clinical outcomes system Clinical teams engagement
Support required:	<ul style="list-style-type: none"> Agreement by Provider Board Financial support for rolling out

The programme of work through which the Pathway Board will achieve the objective should be outlined below. This can take whatever form the Pathway Board considers appropriate. Two suggested formats are provided.

Work programme		
Action	Resp.	By (date)
Invite Jac Livsey to attend PB and give presentation of the Christie system	MW	October 2014
MD to work to work with the outcomes team to refine haematology performas	MD	December 2014
Pilot of the database undertaken at the Christie	MD	July 2015

Work programme

Manchester Cancer

Task	Resp.								
		May-June	July-Aug	Sept-Oct	Nov-Dec	Jan-Feb	Mar-Apr	May-June	July-Aug
Invite Jac Livsey to attend PB and give presentation of the Christie system	MW								
MD to work to work with the outcomes team to refine haematology performas	MD								
Pilot of the database undertaken at the Christie	MD								

Objective 3: Develop a Manchester Cancer trials resource so that all MDT's can access real time information on potential studies.

Objective:	To develop the delivery of information regarding research trials through an electronic-based system, to improve recruitment into clinical trials
Rationale:	To ensure that patients in Manchester Cancer have access to emerging therapies, ultimately improving patient outcomes
By (date):	August 2015
Board measure(s):	Clinical Network Research report
Risks to success:	Infrastructure within the Clinical Network to facilitate requests
Support required:	Financial resource to develop an electronic system to support this and input from Research Lead within Pathway Board

The programme of work through which the Pathway Board will achieve the objective should be outlined below. This can take whatever form the Pathway Board considers appropriate. Two suggested formats are provided.

Work programme		
Action	Resp.	By (date)
Consult with Clinical Network Manager and identify requirements for research activity data	SW	July 2014
Report requirements agreed by Research Lead and Clinical Network Manager	SW	September 2014
Develop of additional components of report	Clinical Network Manager	December 2014
Evaluate to determine improvements in research trial activity	Pathway Board	August 2015

Work programme									
Task	Resp.								
		May-June	July-Aug	Sept-Oct	Nov-Dec	Jan-Feb	March-Apr	May-June	July-Aug
Consult with Clinical Network Manager and identify requirements	SW								

Manchester Cancer

for research activity data									
Report requirements agreed by Research Lead and Clinical Network Manager	SW								
Develop additional components of report	Clinical Network Manager								
Evaluate to determine improvements in research trial activity									

Objective 4: To improve surgical access for lump excision

Objective:	<ul style="list-style-type: none"> To understand where the delays in lump excision are within the region and why To reduce the delays in lump excision
Rationale:	Improving patient experience with reduced waiting times for biopsies facilitating earlier treatments and improved outcomes
By (date):	2 years Audit of lymphoma breaches
Board measure(s):	Questionnaire to Pathway Board members to identify current surgical accessibility
Risks to success:	<ul style="list-style-type: none"> Lack of surgical capacity Lack of radiology capacity
Support required:	Support from Trust Cancer Leads groups to ensure and barriers to access are addressed

The programme of work through which the Pathway Board will achieve the objective should be outlined below. This can take whatever form the Pathway Board considers appropriate. Two suggested formats are provided.

Work programme		
Action	Resp.	By (date)
Questionnaire regarding current accessibility to be completed	MD	August 2014
Review of 2 week breaches	Pathway Board	September 2014
Draft a report highlighting the areas of significant clinical need	MW/MD	November 2014
Disseminate report to Clinical Leads	MW	December 2014

Work programme									
Task	Resp.	May- June	July- Aug	Sept - Oct	Nov- Dec	Jan- Feb	March- Apr	May- June	July- Aug
		Questionnaire regarding current accessibility to be completed	MD						
Review of 2 week breaches	Pathway Board								
Draft a report highlighting the areas of significant clinical need	MW/ MD								
Disseminate report to Clinical Leads	MW								

Appendix: Manchester Cancer Provider Board objectives

The Manchester Cancer Provider Board has identified the themes of its three key objectives. The precise wording of those objectives remains to be confirmed.

- 1. 1-year SURVIVAL:** Focus on improving 1-year pooled cancer overall survival rate, so that we halve the survival gap with the world's best (Sweden) for patients diagnosed in 2020, and approach their figures by 2025
- 2. Patient EXPERIENCE:** Achieve year-on-year improvement in patient experience aspiring to be the best performing conurbation in the National Cancer Patient Experience Survey
- 3. RESEARCH and INNOVATION:** Increase patient involvement in research (>40% by 2019) and be an international leader in developing innovation in clinical practice

16. Appendix 5 - Manchester Cancer Haematological Oncology Summary of MDT review June 2014

As part of the an initial appraisal of the Haematological Oncology pathway the chair of the pathway, Dr Mike Dennis, liaised with the MDT lead clinicians initially through a questionnaire (app. 1) then visited all the individual MDT's from 02.06.2014 to 20.06.2014.

In general they are well lead and co-ordinated with excellent administrative support. There is a strong collegiate atmosphere within all groups and genuine evidence of a patient centred approach to the management plans for patient care.

Broadly the peer review measures are addressed- with each MDT to imminently undergo internal revalidation in 2014.

Pathology/HMDS

Pathology support is highly variable with many MDT's having a pathologist and other allied specialties (cytogenetics) in attendance. Numerous cases were discussed where diagnostic uncertainty remained (especially in lymphoma) and a lack of specialist input was a potential barrier. Almost universally there was recognition that a local HMDS would be preferable if it is a quality service- both in terms of turn-around-times and diagnostic accuracy.

Clinical Oncology

In recent months there has been further improvement in provision with Professor's Illidge, Cowan and Dr Harris now providing comprehensive coverage to all MDT's the only exception to this, a reported occasional absence from the Central Manchester MDT.

Radiology

All MDT's are well supported with more robust cover arrangements now in place at numerous MDT's. The exception is the Christie (Lymphoma/Myeloma) MDT where there is no support.

Research trials

All MDT's are research active with high priority given to trial consideration for the majority of patients. Some uncertainty remains regarding the availability and patient suitability of some trials.

Biopsy access

A regular issue of discussion relates to timely access to biopsies- most recurrently for surgical procedures and less frequently when radiologically directed. Updated

recommendations for lymphoma diagnosis are anticipated from the Lugano meeting which may have implications for the current approach.

Data Management

Although excellent administrative support was present at all MDT's there is marked variation in the recording of outcomes. Current databases are very primitive and only able to generate the most basic of data, none are capable of producing meaningful patient outcome data as yet, although the web portal may become an exception.

Palliative Care

Although members of the Palliative care teams were rarely in attendance it was universally acknowledged that each MDT had core members with appropriate training and there was a good degree of confidence that the elements of care were being considered and addressed.

A consistent finding in discussion was the balance between the inconvenience of on-site attendance versus the practical but compromised discussions from teleconferencing. In general it was recognised that weekly attendance is required to ensure timely review of cases and implementation of appropriate clinical management. Similarly acknowledged was the balance between MDT size and the knowledge/sub-specialist expertise of core members- currently there is no desire to reconfigure the MDT's- *although integrated working within MDT groups and between different MDT's could be enhanced.*

The findings are summarised in Table 1.

Proposed key recommendations to be incorporated into the 2014 board work plan are:-

Development of a regional Specialist Integrated Haematological Malignancy Diagnostic Service-

Further evaluation of uniform data capture which will allow collection of data to robustly assess patient outcomes, to include optimal utilisation of evolving IT platforms.

Develop a Manchester Cancer trials resource such that all MDT's can access real time information on potential studies.

Appendix 1

Manchester Cancer Haematological Oncology MDT evaluation questionnaire 2014

Lead Clinician

- 1 What is the population covered by the MDT?
- 2 What cases are discussed?
- 3 How many cases were discussed in 2013?
- 4 How many patients entered clinical trials?
- 5 Please specify the Pathology support
Is this adequate?
- 6 Please specify the clinical oncology support
Is this adequate?
- 7 Please specify the radiology support
Is this adequate?
- 8 Please specify the palliative care input
Is this adequate?
- 9 Please specify admin support.
Is this adequate
- 10 Who is the lead for patient/user issues?
- 11 How are patients listed for the MDT?
- 12 How are outcomes recorded?
Is this data regularly analysed to assess patient outcomes?

13 What 3 things could be done to improve your MDT?

Table 1

Host	Central Manchester	The Christie	Pennine	Salford	
Additional sites	Tameside	Macclesfield South Manchester Stepping Hill		Bolton Wigan	
Population (est)	500,000	900,000	820,000	800,000	
Lead Clinician	Fiona Dignan	John Radford	Mike Dennis	Hayley Greenfield	Simon Jowitt
Schedule	Tuesday PM	Friday PM	Wednesday PM	Wednesday PM	Monday PM
VC/Site	VC	Site	Site	VC	VC
Total cases 2013	572	479	420	326	439
Trial patients					
MDT	65 @	@		50	31
Network	60	223*	223*	58	34
Data collection	Somerset	Web portal	Excel	Somerset	Bespoke
Key improvements	Weekly Clinical Oncology Radiology Cover	HMDS Timely biopsy Capacity	HMDS Data management Radiology support	HMDS Data management IT facilities	HMDS Data management Single site based

* combined data
@individual site data

