GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Lung Pathway Board

Lung Pathway Board

Minutes and Actions

Friday 9th November 2018

11:00-13:00

Manchester Airport Marriott Hotel, Hale Road, Hale Barns, Manchester, WA15 8XW

Attendance

Name	Role	Lung Pathway Representation
Matthew Evison	Clinical Pathway Director	
Rachel Allen	Pathway Manager, Greater Manchester Cancer	
Mel Atack	User Involvement Manager, Greater Manchester Cancer	
Anna Sharman	Lead Radiologist, Manchester University NHS Foundation Trust	South Sector Radiology Lead
Anna Walsham	Chest Radiologist, SRFT Salford Radiology Lead, Member of NW Sector MDT Group	North West Sector Radiology Lead
Anne Marie Quinn	Consultant Histopathologist, Manchester University NHS Foundation Trust	Chair of Pathology Sub-Committee
Ben Taylor	Consultant Radiologist, The Christie NHS Foundation Trust	PET Lead
Cathryn Winchombe (deputising for Carol Diver)	Directorate Manager, Tameside	
Coral Higgins	Cancer Commissioning Manager, Manchester Clinical Commissioning Group	Cancer Commissioning Lead
David Weir	Respiratory Consultant, Pennine Acute Hospitals NHS Trust	Trust representative, Pennine Acute Hospitals NHS Trust (NMGH) North East Sector Lead
David Woolf	Consultant Clinical Oncologist, The Christie NHS Foundation Trust	Chair of Optimal Treatment Pathway Sub-Committee Deputy Chair of GM Lung Pathway Board

Duncan Fullerton	Respiratory Physician, Mid Cheshire Hospitals NHS Foundation Trust	Trust representative, Mid Cheshire Hospitals NHS Foundation Trust
Haider Al Najjar	Chest Physician, Manchester University NHS Foundation Trust	
James Whittaker	Consultant Radiologist, Stockport NHS Foundation Trust	Central Sector Radiology Lead
Joanna Gallagher	Consultant in Respiratory Medicine	Trust representative, East Cheshire NHS Trust
John Shuttleworth		Patient representative
Karen Clayton	Lung Clinical Nurse Specialist Lead, East Cheshire NHS Trust	
Kathryn Slater	Lung Cancer Specialist Nurse, Bolton Foundation Trust	
Leena Joseph	Clinical Director (Consultant Histopathologist)	Manchester University NHS Foundation Trust
Louise Brown	Consultant in Respiratory Medicine, Pennine Acute Hospitals NHS Trust	Chair of Tobacco Control Sub-Committee
Nic Clews		Patient representative
Ram Sundar	Chest Physician, Wrightington, Wigan & Leigh NHS Foundation Trust	Trust representative, Wrightington, Wigan & Leigh NHS Foundation Trust North West Sector Lead
Seamus Grundy	Consultant Respiratory Physician (Thoracic Oncology)	Trust representative, Salford Royal Foundation Trust
Simon Bailey	Chest Physician, Manchester University NHS Foundation Trusts (Central)	Trust representative, Manchester University NHS Foundation Trusts (Central) Central Sector Lead
Suman Das	Consultant in Respiratory Medicine, Stockport NHS Foundation Trust	Trust representative, Stockport NHS Foundation Trust

In attendance

Zoe Merchant	Prehab Lead, Greater Manchester Cancer	
Freya Howle	CURE Lead, Greater Manchester Cancer	
Morris Tomlinson	Senior Data Analyst, Greater Manchester Cancer Data Intelligence Team	
Lindsey Wilby	Macmillan Project Manager – Living with and Beyond Cancer, Greater Manchester Cancer	
Alison Armstrong	Programme Lead, Greater Manchester Cancer	

Apologies

Carol Diver	Macmillan Cancer Nurse Consultant, Tameside Hospital NHS Foundation Trust	Trust representative, Tameside Hospital NHS Foundation Trust

		Chair of Living with and Beyond Sub-Committee
Carolyn Allen	Consultant Radiologist, Pennine Acute Hospitals NHS Trust	Pennine Sector Radiology Lead
Catherine Fensom	Macmillan Transformation Project Manager	
Dr Liam Hosie	Lead Cancer GP	Primary Care representative
Durgesh Rana	Consultant Cytopathologist	Manchester University NHS Foundation Trust
Ian Webster	Consultant in Respiratory Medicine, Bolton NHS Foundation Trust	Trust representative, Bolton NHS Foundation Trust
Janice Delaney		Patient representative
Jayne Holme	Consultant Respiratory Physician, Manchester University NHS Foundation Trust	Chair Regional Mesothelioma MDT
Kandadai Rammohan	Thoracic Surgeon, Manchester University NHS Foundation Trust	Chair of Optimal Treatment Pathway Sub-Committee
Kath Hewitt	Specialist Thoracic Nursing Lead, Manchester University NHS Foundation Trust	
Nyla Nasir	Consultant Histopathologist, Mid Cheshire Hospitals NHS Foundation Trust	Mid Cheshire Hospitals NHS Foundation Trust
Phil Barber	Consultant Respiratory Physician, Manchester University NHS Foundation Trust	Co-chair of Tobacco Control Sub-Committee
Prof Fiona Blackhall	Medical Oncology Lead, The Christie NHS Foundation Trust	Chair of Research Sub-Committee
Rajesh Shah	Consultant Thoracic Surgeon, Manchester University NHS Foundation Trust	Thoracic Surgery Lead
Richard Booton	Consultant in Respiratory Medicine, Manchester University NHS Foundation Trust	Trust representative, Manchester University NHS Foundation Trust Chair of Optimal Diagnostic Pathway Sub-Committee South Sector Lead
Thapas Nagarajan	Consultant in Respiratory Medicine	Trust representative, East Cheshire NHS Trust

1. Welcome and introductions

ME opened the Board and welcomed attendees.

2. Board minutes and review

Discussion summary	ME welcomed RA as the new Pathway Manager for the lung board, taking over Claire O'Rourke who has been promoted to Associate Director for Greater Manchester Cancer. It was noted that RA is currently supporting six Greater Manchester Cancer Pathways within her portfolio; lung, skin, head and neck, childrens, TYA and breast (temporarily until a further Pathway Manager commences in role).

	The Greater Manchester Cancer structure has been updated with new roles including Miss Susannah Penney as Associate Medical Director. ME highlighted the opportunity to formalise the Board in terms of minutes, attendance records and Terms of Reference (ToRs). Work is underway to develop consistent ToRs for all Greater Manchester Cancer Pathway Boards which will be finalised in the next few weeks and shared with members for review. ME highlighted the need to ensure representation from all Trusts and disciplines. Where attendance is light, ME may write to members to consider alternative representation.
Actions and responsibility	**a) RA share draft ToRs with Board members once they are developed.**

3. Greater Manchester (GM) optimal pathway

Discussion summary	ME presented the GM-wide Optimal Lung Cancer Pathway proposal and summarised the investment secured from the GMHSCP Transformation Fund for its roll-out across the conurbation. ME highlighted that the proposal is based on the RAPID programme currently in operation at Wythenshawe Hospital (Manchester University Foundation Trust). ME summarised the impact of rapid pathways on survival and patient experience and provided an overview of how the Wythenshawe RAPID programme was established. A summary of the criteria for accessing the Transformation Fund was shared along with the process for implementation of a scaled-up programme across GM. Findings from the 2015 Lung BOOST Study were discussed. The research demonstrated the impact of EBUS in generating a much faster pathway to 14 days vs 30 days on average. In post-hoc analysis there is a clear and significant survival difference in those on a 14 day pathway vs 30 day pathway with median survival 300 days vs 500 days. ME noted that one of GM's ambitions is to improve one year survival across the region. ME spoke of the evidence base that builds the picture that times matters in lung cancer care and highlighted the similarity to the 'golden hour of trauma'. An overview of the lung cancer pathway at Wythenshawe pre-implementation of RAPID was described. A quarter of people were seen within the first 7 days; 75% within the first 14 days which meant that a quarter were not having a CT scan within the national 14 day standard. Patients waited an average of 6 days from CT scan to OPA; 24% of patients had a OPA within 7 days of referral; 84% of patients had an OPA within 14 days of referral; 46% of patients discussed at a treatment MDT within 28 days of referral. ME highlighted the areas to be addressed for improvement including underutilisation of resources. The ideal pathway was described including: • Immediate and efficient CT booking process from referral to CT • Dedicated / 'ring-fenced' RAPID CT slots 8-9am • Real-time radiology vetting & IRMER compliance • Radiology vetting to include regional radiology history review • Point of care eGFR testing

	• Same day hot reporting of RAPID scans • Same day physician-led triage of CT report and patient consultation • Chest medicine & radiology integrating into the RAPID team • Geographical co-location: RAPID Hub • RAPID Patient navigator – link between call centre, patients and clinicians – Band 5 ME highlighted that there is no change to the number of patients seen and/or number of scans performed – it is the organisation and stratification of patients and scanning activity that is rationalised. The idea underpinning the proposal is for the following to be completed in one working day: CT scan and report, triage, specialist consultation, CNS support and protocolised diagnostic and staging pathway to commence (and diagnosis of no cancer). ME described the co-location arrangements at Wythenshawe which are incredibly important for the optimal lung cancer pathway. A summary of patient experience feedback was shared. It was noted that the NHS England 'implementing a timed diagnostic pathway' handbook (April 2018) outlines the Wythenshawe RAPID pathway specifically and many of the features of a faster pathway. £1,351,750 Transformation Fund investment was secured in Autumn 2018, as one of the priority Greater Manchester Cancer proposals. ME reminded the Board of the gap analysis that was undertaken. It was noted that not all sectors completed the exercise. Specific requests that came out of exercise have formed the basis for the TF bid. ME highlighted that consultant posts cannot be funded via TF. ME described the application process now in place to demonstrate that sector requests are in line with the optimal pathway components (front end, diagnostic and treatment; sectorised delivery of test bundles). ME articulated the need to see job plans – roles will not be funded to be taken into other areas of hospital care. The lead employer of all roles will need to be defined for sectorised roles. Commitment from trusts on sustainability of trusts will need to be clearly communicated. ME highlighted that every component of work being funded through the Greater Manchester Cancer Transformation programme must have a clinical lead. Greater Manchester Cancer will remunerate one PA to the trust that takes the position of clinical lead. ME welcomed expressions of interest to assume the role of Clinical Lead for the GM Optimal Lung Pathway. ME clarified that the funding is in place up to March 2021. RA referenced recruitment underway for a dedicated full-time Band 8a Programme Manager to lead and oversee implementation of the entire project from a programme management perspective. A discussion ensued on the south sector's ability to draw down funding: Leighton and Macclesfield will need to consider the requirement for delivery - Wythenshawe does not need any additional specific investment from this funding stream. It was noted that the gap analysis was undertaken early 2018. ME clarified

	that sectors may wish to amend their financial ask from the original sector gap analysis as there is flexibility within the £1.3m financial envelope attributed to this project. It was highlighted that owing to the definitive investment amount, securing funding for each sector is a competitive process. BT commented on how delays in radiology reporting will impact upon delivery of the optimal pathway and queried the dedicated radiology resource available. ME clarified that there would be no extra reporting – this work will involve reorganisation of existing reporting arrangements as opposed to increased demand. Outsourcing of radiology was discussed. ME offered to meet with hospital teams to share experiences of the Wythenshawe RAPID programme to help promote the programme to teams affected by any change as required. A discussion ensued on Dr Roger Laitt's (RL) proposed hub and spoke radiology model in GM. It was noted that a GM PAC is in development (expected Spring 2020). CPD education for radiographers was discussed to speed up elements of work that are controllable.
Actions and responsibility	**a) Sectors to meet with sector leads to define sector needs and develop a proposal articulating the financial ask for implementation of the optimal lung cancer pathway to RA and ME as soon as possible. A detailed description of how the sector's ask aligns to objectives of the programme is required.** **b) RA to share job description for the Clinical Lead for the GM Optimal Lung Pathway with all Board members for interested members to apply for. A formal recruitment process will be followed.**

4. Pathway performance

Discussion summary	ME welcomed Morris Tomlinson (MT) to describe current pathway performance and an update on the development of a dashboard to measure the GM optimal lung pathway. MT highlighted that the data presented is from the Cancer Alliance Data Evidence and Intelligence Service (CADEAS), which is part of NHS England. The figures are presented to Greater Manchester Cancer (from NHS England) as the cancer alliance. Two week wait compliance was 98% across Q1 and Q2 of 2018. MT explained the inability to draw down and look at first referral to first seen as only aggregate data is available. Classic 62 day wait (GP referrals) compliance was 71.5% (Q1) and 79.6% (Q2). MT explained that the consultant upgrade data may need more investigation. Janet Smart (JS) explained that the high number of upgrades is due to Trusts changing the way the data is inputted. MT described the 62 day compliance trend between May and September 2018 from 68.4% to 85%. An overview of the optimal lung cancer pathway dashboard was presented. The dashboard mirrors the optimal pathway and will hopefully offer a way of measuring performance going forward and is split by treatment so that

	delays can be investigated. Once up and running, Trusts will be given access to the dashboard.
Actions and responsibility	**a) RA to organise access to the optimal lung cancer pathway dashboard for those interested once it is finalised.**

5. EBUS review

Discussion summary	CH explained that following the Board meeting in July, Adrian Hackney (AH) proposed a review of capacity and demand and activity in GM around EBUS provision across the region. A proposal has been developed between CH and Jen Riley (JR). Board members were invited to comment on the proposal which was circulated in advance of the meeting. This is separate to the normal EBUS performance report that ME has developed. The next step will be to develop a tool to collect the data with RA's support to collect the data from providers. EBUS performance data will be requested for 2017 with an end of the year deadline. ME will gather the data by the end of the year. A report will go to commissioners by the end of March 2019 with an opportunity to meet with commissioners. Board members were invited to comment on the paper (Paper 5). It was noted that East Cheshire was omitted from the document but would like to be included going forward and so CH will need to have access to East Cheshire's EBUS performance data going forward.
Actions and responsibility	**a) Board members to submit written expression of interest to ME (via Pathway Manager, RA) by COP Friday 30th November 2018 to apply for the role of Clinical Lead for the EBUS Review.** **b) RA to support collection of EBUS data from providers to inform service review.**

6. Prehab / rehab / ERAS+

Discussion summary	ME reminded Board members of the Prehab pathway. ME highlighted that when referring patients to surgery, surgery school should be mentioned. It was noted that the majority of hospitals now have surgery school in place. If there is not a local surgery school for those patients referred to Wythenshawe, patients will be contacted by navigators at Wythenshawe and offered a place there. SG queried the eligibility criteria to send lung patients to local surgery school and requested very clear guidance on how to refer to local surgery school. Zoe Merchant (ZM) clarified that if somebody can go, whether close to home or in place of treatment, it is encouraged because of the benefits it presents. It was noted that Wigan is charging patients through a council subsidised scheme and so needs further consideration. ME spoke of the ERAS+ website that is up and running which can be used to signpost patients and a patient information leaflet is available which is generic across all trusts. ZM (Prehab Programme Lead) provided an overview of the Prehab

	programme which is being funded through TF for the next 2 years and is closely aligned with ERAS+. It was noted that ZM is a Specialist Occupational Therapist with a neurological rehabilitation speciality background. ZM explained that Prehab will involve working with GM Active to deliver an exercise referral scheme in gyms and leisure centres for specific patients. There is capacity to reach 2,000 patients over the 2 years programme. ZM and clinical lead, Dr John Moore are building on existing research undertaken by Prof Sandy Jack. The Prehab programme aligns with the Macmillan Recovery Package which is being implemented across GM. Current evidence indicates that high risk patients benefit from a 2-4 week intensive exercise programme prior to treatment. Lower risk patients are being shown from deriving less benefit from intensive Prehab prior to treatment. The programme team intend to offer something for all patients working with leading GM physiotherapists around home exercise packs at point of diagnosis and surgery schools specific to tumour condition as contraindications. There was a query around how the Prehab programme fits with specialist pulmonary rehabilitation programmes already being delivered by AHPs widely. ZM advised that the Prehab programme is building on pulmonary rehabilitation and cardiac rehabilitation schemes already being delivered often in partnership with the leisure providers. The team are working with such experts to co-design and deliver Prehab/rehab. The immediate Prehab focus will be the lung, colorectal and upper GI pathways based on the current evidence base. A preliminary workshop specifically on the lung pathway and how prehabilitation fits with it was held in October. Delegates were supportive of the proposal and the need for patient criteria was discussed. ZM described the governance arrangements for the Prehab programme for the lung pathway including the establishment of a Steering Group, the first meeting of which will be held on the 14th December 8:30-10:30am. All Lung Pathway Board members are welcome to attend.
Actions and responsibility	**a) SG requested clear guidance on how to refer patients to prehab service. ZM to address this – RA to follow-up.** **b) RA to share Lung Prehab Steering Group meeting details (14th Dec). Interested board members to join Group.**

7. CURE programme

Discussion summary	FH was invited to update on the CURE launch at Wythenshawe. FH offered to share the overview document of how the pathway was implemented, and all the working groups it took to mobilise CURE for any Board members interested in the operational detail. CURE launched on the 1st October at Wythenshawe Hospital site. Media coverage was led by ME and Cheryl Pearse (Lead Smoking Cessation Nurse) offering interviews for both TV and radio. It was noted that despite teething issues, CURE has been well received, and the Specialist Nurse service activity has been increasing as expected: • Receiving 20 referrals per day compared to previous 20 referrals per week

	• Specialist Nurse team not just seeing CURE patients – still also receiving non-CURE referrals from maternity, AE, outpatients & staff etc.
	• If the expected number of referrals ~2500 (over 6months) was split equally each month the expectation is for ~417
	  o October there were 329 CURE referrals
	  o Will monitor this number every month via the hospital Steering Group
	• Around 3500 smoking status' recorded in October
	
	Currently the main risk internally is the issues with the updated referral system that has been built in EPR (Electronic Patient Records). IT completed work before launch to make the nursing assessment easier to complete, and also automated the referral process to the Specialist Nurse team, however there are some problems with missing and duplicate referrals that have been raised with the EPR team who are working to resolve as a priority.
	
	Formal evaluation will begin in January 2019, led by Pfizer as per a joint working contract, which will produce 3, 6 and 12 month reports looking at the following outcomes:
	• Reduction in readmissions at 30 days
	• Increase in quit rates
	• Reduction in AE admissions
	• Reduction in mortality rate at 1 year
	
	A discussion ensued on pharmacy cost. FH explained that the impact on pharmacy will be monitored internally, with finance reporting the cost broken down by medication each month. However currently the actual cost will most likely be significantly less than the estimate, which was made, based on a 90% uptake and the most expensive treatment option as only 25% of October patients identified as having a high level addiction.

Actions and responsibility	**a) RA to share the CURE overview document of how the pathway was implemented for any Board members interested in the operational detail.**

8. Macmillan Recovery Package

Discussion summary	The implementation of the Recovery Package (RP) throughout GM is one of the key objectives in the Greater Manchester Cancer Plan. Lindsey Wilby (LW) explained that the purpose of pathway mapping is to agree where each element of the RP (particularly Holistic Needs Assessments (HNA) and treatment summaries) should be implemented, as this will vary for each patient dependent upon both the trusts involved, and the pathways in question. A group of Lung specialist nurses, representing all of the trusts in the GM region, and supported by members of the Greater Manchester Cancer core team and PABC, came together at a workshop in July 2018 to agree the pathways for their patients. LW asked the Board to agree that the pathways included in the document reflected practice across the region as they understood it, and to note two specific issues that had arisen during the workshop: 1. Numerous gaps in resources were highlighted, meaning that some teams were not in a position to deliver the interventions in question at some points in the pathway. The board was asked to be supportive of any business cases that might be submitted in order to address

	inadequacies in provision. 2. The surgical centre at MFT (South) currently completes a HNA for all patients 4 weeks post-surgery, and then hands any concerns raised back to the local/diagnosing Trust to action during further treatment or follow up. Local teams were concerned that this would then necessitate a repeat HNA at the diagnosing Trust in order to ensure that accurate and full information is available for referral to local community services – and that two HNAs within a very short space of time is onerous for patients, repetitive and unnecessary. Local teams felt that a local HNA post-treatment would therefore be in the patients' best interests (and indeed this is the expectation in the GM standardised approach to the implementation of the RP). This concern was reiterated at the Pathway Board meeting by KS.
Actions and responsibility	**a) Board members asked to be supportive of any business cases that might be submitted in order to address inadequacies in provision of recovery package interventions.**

9. MDT reform

Discussion summary	ME spoke of the work led by Chris Harrison (National Clinical Director for Cancer) and Martin Gore (Ex Medical Director of the Royal Marsden) on MDT reform. It was noted that the lung cancer community were not in favour of proposals to reorganise and rationalise lung cancer MDTs. ME invited board members to make contact with any ideas to improve MDT efficiency.
Actions and responsibility	**a) Board members to share any ideas to improve MDT efficiency with ME and RA.**

10. Macmillan User Involvement Team update

Discussion summary	MA highlighted that service users have been involved in all of the programmes of work discussed at the Board. It was noted that the Macmillan User Involvement Team have a developed workplan of key deliverables. MA requested to meet with ME, RA and the three patient representatives before Christmas 2018 to take the User Involvement work plan forward.
Actions and responsibility	**a) ME, RA and the three patient representatives to meet before Christmas 2018 to take the User Involvement work plan forward.**

11. Greater Manchester Cancer lung board education events

Discussion summary	The notion of a 2019 Lung Education Day was discussed. ME highlighted the need for a dedicated education lead from the Board and invited board members to consider the education leadership position. ME highlighted the upcoming Greater Manchester Cancer Conference taking place on the 26th November. It was noted that further rounds of tickets may be available. RA to share registration link.

Actions and responsibility	**a) Board members to submit expression of interest to ME (via Pathway Manager, RA) by 31st December 2018 to apply for the role of Clinical Lead for Lung Education** **b) RA to share details of Greater Manchester Cancer Conference for Board members to register for any remaining places.**

12a. AOB – Weight loss with a normal CXR

Discussion summary	SB raised the issue of weight loss with a normal CXR. The issue was discussed at the MRI lung cancer operational meeting and the need for guidance The questions were: 1. Should these patients have CT T/A/P up front and be seen by clinicians and referred back to GP if no cancer 2. Should they have STAGING CT THORAX and back to GP if no cancer 3. Should they be referred on by clinicians to another speciality (?gastro) post 1 or 2 4. Is there still a 'vague symptom' HSC205 pathway that these patients can go down (the previous pilot at Wythenshawe/Oldham was noted – the ACE Pathway) A discussion ensued on the vague symptoms pathway in existence. Colleagues from Whiston offered to advise SB further.
Actions and responsibility	**a) DF (Whiston) and SB (MRI) to discuss the issue of weight loss with a normal CXR and establish guidance on the issue.**

12b. AOB – Pharmaceutical support

Discussion summary	ME informed Board members of the offer of support from a number of pharmaceutical companies including project management assistance. RA is able to connect board members to pharmaceutical contacts as appropriate.
Actions and responsibility	**a) Board members to get in touch with RA for further details on pharmaceutical offers of support as required.**

12c. AOB – GM Malignant Airway Obstruction Protocol

Discussion summary	The GM Malignant Airway Obstruction Protocol was shared with Board members in advance of the meeting. ME highlighted that this will form an agenda item at the February Lung Pathway Board.
Actions and responsibility	**a) RA to include GM Malignant Airway Obstruction Protocol on February Lung Board agenda.**