GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Agenda

Meeting time and date: 8.00am-10am Friday 2nd November 2018

Venue: Frank Rifkin 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 1	Note	Richard Preece	
4	Update from GM Cancer User Involvement Steering Group	Verbal	Note	Sarah Haworth Nabila Farooq Ian Clayton	10′
5	Skin Cancer Services Update : GM Pathway Director Update	Paper 2/ Presentation	Discuss	John Lear	20’
6	Genomics in GM & pathway board update	Presentation	Discuss	Fiona Blackhall	20’
7	62 day: Cancer referral increase in GM	Paper 3/ presentation	Discuss	Susi Penney	20’
8	Single Surgery Cancer Models – Programme Implementation Update	Paper 4/ presentation	Note	Sarah Maynard-Walker	20’
9	Papers/ updates for information: ▪ DIEP service update ▪ GM Cancer Conference	 Paper 5 Flyer attached	 Note Note	 MFT Dave Shackley	20’
10	Future Meeting Dates: ▪ **18th January 2019:** 8-10am ▪ **8th March 2019:** 8-10am ▪ **3rd May 2019:** 8-10am ▪ **12th July 2019:** 8-10am ▪ **13th September 2019** 8-10am				

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Minutes of Greater Manchester Cancer Board

Time & date: **8.00am-10.00am Friday 7th September 2018**

Venue: **Frank Rifkin Lecture theatre, Mayo Building, SRFT.**

Chair: **Dave Shackley**

Medical Director - GM Cancer		David Shackley	DS	Medical Director, Greater Manchester Cancer
Specialised Commissioning		Suzanne Fennah	SF	North of England Specialised Commissioning Team (North West Hub)
Commissioning		Darren Griffiths	DG	Associate Director of Finance GM Cancer
Provider Trusts	Salford	Jack Sharp	JS	Director of Strategy
	Manchester FT	John Waring	JW	Director of Strategy
	The Christie	Roger Spencer Chris Harrison	RS CH	Chief Executive Medical Director
	Pennine	Roger Prudham	RPr	Deputy Medical Director
		Cara Pursall (Deputising for Janet Butterworth)	CP	Programme Lead for Cancer and Elective, Performance and Delivery
Director of Operations group		Marie Hosey (Deputising for Fiona Noden)	MH	Deputy Director of Operations, the Christie
People effected by Cancer		Ian Clayton	IC	User representative
People affected by Cancer		Nabila Farooq	NF	User representative
User Involvement GM Cancer		Sarah Howarth	SH	Macmillan User Involvement Programme Manager
Eastern Cheshire CCG		Sally Rogers	SR	Director of Quality
Nursing Leadership		Cheryl Lenney	CL	Director of Nursing, MFT
Manchester Cancer Research Centre		Rob Bristow	RB	Director of MCRC
Nursing Leadership		for Chery Lenny	CL	Director of Nursing, MFT
Christie School on Oncology		Cathy Heaven	CH	Associate Director, Christie School of Oncology
GM Cancer		Claire O'Rourke	CoR	Associate Director, GM Cancer
GM Director of PH Transformation		Siobhan Farmer(Deputising for Jane Pilkington)	SFa	Healthcare Public Health Consultant & Screening and Immunisation Lead

Cancer Research UK	Nicola Harrison-Swanston		North Regional Manager

In attendance

GP perspective on Cancer services across GM	Sarah Taylor	ST	Cancer Lead GP for GM Cancer
Pathway Director Reviews Presentation	Susi Penney	SP	Associate Medical Director, GM Cancer
Breast Pathway Board Presentation	Mohamed Absar	MA	Clinical Director GM Cancer Breast Pathway Board
GM Cancer	Rachel Allen	RA	GM Cancer
GM Cancer	Michelle Leach	ML	GM Cancer
GM Cancer	Fiona Lewis	FL	GM Cancer
GM Cancer	Alison Armstrong	AL	GM Cancer
	Ryan Donaghey	RD	Provider Federation Board
	Catherine Perry	CP	University of Manchester-RESPECT 21

1. **Welcome and apologies**

DS welcomed all to the meeting and noted the apologies received. He then invited the participants to provide introductions.

2. **Minutes of the Last meeting**

These were accepted as a true record.

3. **Action Log and Matters Arising**

ACTION		**STATUS**
1	Progress report on Genomics Board to report back to the GM cancer board in September 2018.	Deferred to November Board
2	Update on proposed UI locality workshop	COR and SH have completed

4. **Update from GM Cancer User Involvement Steering Group**

Locality work is under way; comments will be added by UI team under each agenda Item. No other specific update.

5. **Breast Cancer Pathway Board Update**

Mr Absar, Clinical Director for the Breast Pathway Board spoke about some of the successes and challenges of the Breast Pathway Board. He explained about the work being carried out on single breast service across GM and the published standards and guidelines on the GM Cancer website. He discussed the Bisphosphonates therapy work which has now been rolled out across GM to all eligible women. The board is also working towards a single research service so that all patients can get onto appropriate trials, this remains a challenge however. He also spoke about the work around the recovery package and the board will continue to work to implement this for all breast patients over the coming 12 months.

A challenge for the board was engagement in the board work and they have improved this by forming subgroups where the board members are doing more work outside of the meeting and becoming more productive as a result.

A key concern of the breast pathway board related to the ongoing issue with Deep Inferior Epigastric Perforator Artery (DIEP) services in GM. Wythenshawe was designated as the provider for the DIEP service but 3 months ago the service was withdrawn in selected patients due to a number of factors, which has caused considerable disquiet.

SR commented that Bisphosphonates will shortly be offered in East Cheshire after working with the Christie. IC congratulated the Breast Board on their 62 day figures. He asked why there is not more patient and commissioning involvement in the resolution of the DIEP service issue. DS explained that there is a group from MFT working with commissioners to resolve this issue.

ACTION – MFT to provide an update report on the DIEP issue at the next GM cancer board.

6. GM Screening Update

SFa presented an update on the 3 GM Cancer Screening Programmes. Key headlines were that GM is consistently screening more people each year, and the health inequalities gap to England has been reduced across all three programmes. A brief outline of the data available and how it is used was given. The most up to date data nationally is from 2017 due to the time it takes to clean and then attribute the data to the correct geography. Moving forward the team will be producing more visual and hopefully interactive dashboards, and access has been gained to more up to date data, albeit at a programme rather than CCG level.

SFa explained the priorities for the forthcoming year, including work to understand inequalities and barriers to screening uptake and collaborative work with primary care and the public. The team are also looking for innovation projects e.g. piloting self-sampling for HPV.

An update was provided on the national picture. The Bowel Screening Programme will move to FIT test for screening for bowel cancer, and a recent recommendation from the National Screening Committee suggests that the age range will be broader, starting at 50 in future instead of 60 (although no timescales are confirmed). Breast screening is moving over the next few years to "next test due date" which means that all women will be invited at 50 and then again 3 yearly. Cervical will convert to HPV primary screen. She commented that HPV vaccination will commence in boys at some point in the future.

RS asked are we picking up and identifying more cancers through screening and where does GM stand in the National picture. SFa explained that there are national minimum standards and Manchester are meeting for bowel but not for the other breast and cervical at this time, however, this could be reviewed with the support of PHE Quality Assurance.

Action: SFa will present a further update to the board in 6 months which will update on the progress of the programmes of work outlined at this meeting.

7. GP perspective on Cancer services across GM

ST explained about the referral guidelines and the issues GP's face with understanding them particularly where patients could be referred to a number of different pathways. She discussed the work carried out in GM around a standardised referral form for suspected cancer for GP's, which was easier for them to use and better for the receiving Trust to interpret.

They have also been working on the ACE programme, secondary care triage, early diagnosis and FIT for low risk symptomatic patients. She talked to the group about the Gateway C programme which is helping educate GP's and they are working towards increasing uptake of this programme with potentially a mandatory module. All CCG's also have cancer standards for GP's. Work is being done on behavioural insight to help the GP practices understand their uptake of screening. CH commented that the FIT for symptomatic patients was a great concept and the quicker the data from the pilot at Stockport could be shared and the scheme scaled up and spread the better as this could be very impactful

She asked that the provider Trusts provide clear protocols for reporting results and clearer communication of the results and the pathway that their patients will be undertaking. They would also like robust data around incorrect referrals and constructive feedback which can be shared and analysed.

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Action - DS and ST to work together to decide upon the best way to move each of the issues forward in the next 3 months.

8. GM Cancer Conference Update

DS explained the background to the cancer conference. He explained although it is a celebration event is also a chance to talk about new and innovative ideas to change the Cancer services across GM. Andy Burnham will be opening the day and all members of the board will have a place there and 40 spaces are for patient representatives. There will be a break out area where all the pathway boards will have a chance to showcase their work. CH left fliers for the group to take back to their teams regarding admitting abstracts.

9. 100k Genome: progress report & update

DS explained this has been extended nationally and Fiona Blackhall will come and speak at the next board around how a GM genomics service will work.

10. 62 day cancer standard

SP talked about the Q1 performance data and the poor outcomes from this. She discussed a piece of work she is leading in GM, in her role as Associate Medical Director with GM Cancer, to look at the increase in volumes of patients referred into the service compared with cancer diagnosed and the bearing of this on the 62 day figures. SP explained that there is a large capacity and demand issue and diagnostic services are under immense pressure. She explained that an example of good practice to move patients through the system is FIT for symptomatic patients. A discussion ensued about where the issue is i.e. is it trained staff or space to see the people and the answer was it's a mixture of both. The referral procedure was discussed by the group and the difficulties around this which again highlights the work being done by ST around this area.

DS asked CH how he feels GM is doing in comparison with the national picture. CH said the figures are comparable. He went on to talk about the reduction in of the31 day target to 28 days and this will again affect the figures and compliancy rates. He said that GM is potentially ahead in terms of screening i.e. the FIT for symptomatic patients.

He also commented that GM having a multi-disciplinary cancer board is helpful for solution finding. DS agreed that this board's aim is to help move the worst performers forward and CH agreed that collaboration was key to this.

DS explained that SP is doing lots of work to drive figures up. SP is currently involved in the following initiatives:

- SP is working with the Pennine and East Cheshire
- GM Cancer working towards the best timed pathway aligned with transformation funded projects
- DNA's – work needs to be done as to why patients DNS

ACTION – CH said as Pennine are currently the worst performers he is currently working with the Northern Care Alliance and SP to help support them to achieve better outcomes regarding the 62 day targets and will update the board on progress on this.

ACTION-SP to produce a report for next cancer board with cancer intelligence team in GM and GMH&SCP on referral increases in GM.

11. Pathway Director Reviews

SP told the group that 15 Pathway Director reviews had been done and there are 2 vacancies. All boards have made great progress and she congratulated them on behalf of GM Cancer for their work. Each Director produced a summary report updating the board on the work done in the previous work and what would be done in the coming year. She highlighted various areas of good practice across all of the boards and explained that a full report is being produced and this will be showcased at the upcoming conference. JS asked how we are identifying what good practice carried out in individual boards could be embedded in other areas of work. SP said that the annual reviews will inform this and also they will be asking pathway directors to present at Trust Leads meeting in the future.

12. Papers/updates for information and AOB

- Be clear on Cancer Campaign – Blood in Pee campaign at the moment which may mean an impact on all the provider services.
- **NHS 10 year plan – Cancer work stream**
  RS will be representing the North with regards to the long term plans for Cancer. In terms of GM the RS will draw on the expertise around the table. He will also be incorporating learning from the devolution work in GM.
  He explained the following priorities for this work

    - By 2028 70 % of patient will be cured (matching European survival rates)
    - Earlier diagnosis
    - Optimising access
    - Research & Innovation

13. Future Meeting Dates

DATE	TIME	VENUE
18/01/19	8-10am	FRLT, SRFT
08/03/19	8-10am	HBLT, SRFT
03/05/19	8-10am	HBLT, SRFT
12/07/19	8-10am	HBLT, SRFT
13/09/19	8-10am	HBLT, SRFT
01/11/19	8-10am	HBLT, SRFT

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NHS in Greater Manchester

Greater Manchester **Cancer**

Action log

Prepared for the 2nd November 2018 meeting of the board

	ACTION	AGREED ON	STATUS
1	Progress report on Genomics Board to report back to the GM cancer board in September 2018.	13th July 2018	Presentation November board 2018
2	DS requested a report on the DIEP surgical plan by MFT to be discussed at the next GM cancer board.	7th September 2018	Paper to November board 2018
3	SP to produce a report for next cancer board with cancer intelligence team in GM and GMHSCP on Cancer referral increases in GM.	7th September 2018	Paper to November board 2018

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Paper number 2

Date: Friday 2nd November 2018

Title: Greater Manchester Cancer Skin Pathway Update

From: Dr John Lear

Purpose of paper

This paper aims to provide a summary of skin cancer prevalence in Greater Manchester and current pathway performance. The paper also introduces the Greater Manchester Cancer Skin Pathway Board's 2018/19 work programme and areas of particular focus.

Recommendations

The Greater Manchester Cancer Board is asked to:

1. Endorse the 2019/19 work programme set out.
2. Support the implementation of the Pathway Board's plans for MDT reform.
3. Consider and support the proposed project focused on supporting skin cancer referral pathways and help to identify potential investment streams to resource the pilot.

Contact

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1.0 Skin cancer prevalence in Greater Manchester

1.1 Referrals, diagnoses and treatment

Skin referrals are the third highest in Greater Manchester and Eastern Cheshire after Breast and Lower GI (Figure 1), accounting for 14% of all suspected cancer referrals in a five year period (2012-2017).

Over 3 years, referrals have increased by 31% with diagnoses/treatments increasing by 20% (Figures 2 and 3).

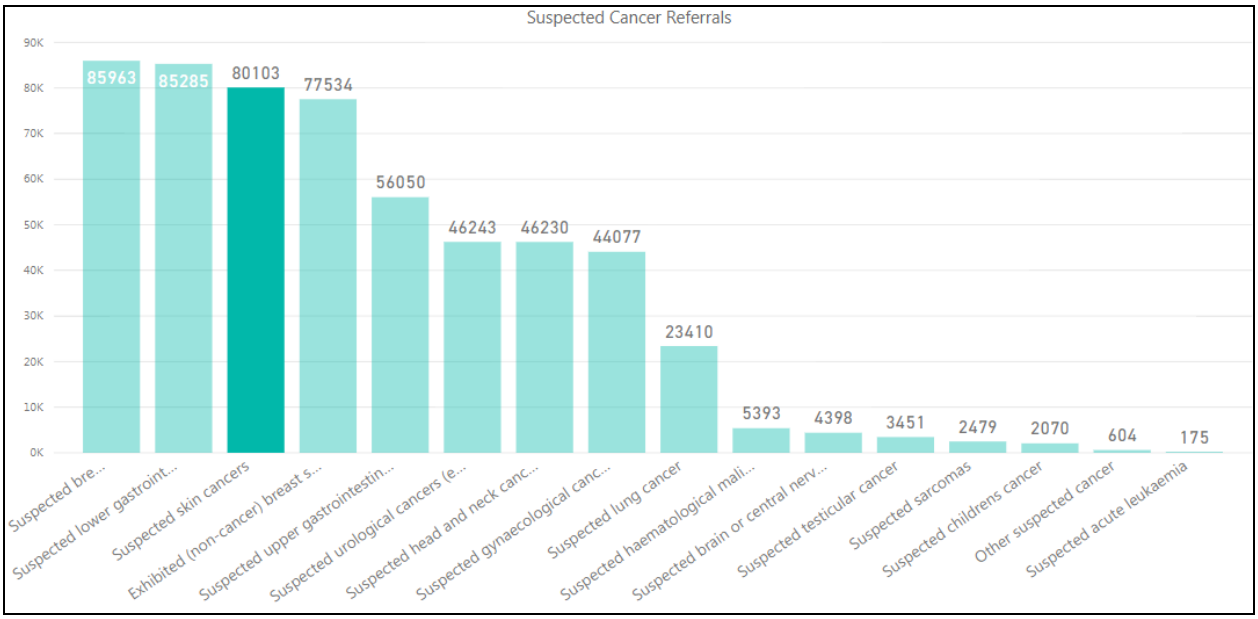

Figure 1. Number of suspected cancer referrals 2012-2017 for all cancers in Greater Manchester and Eastern Cheshire. Data source: Open Exeter CWT.

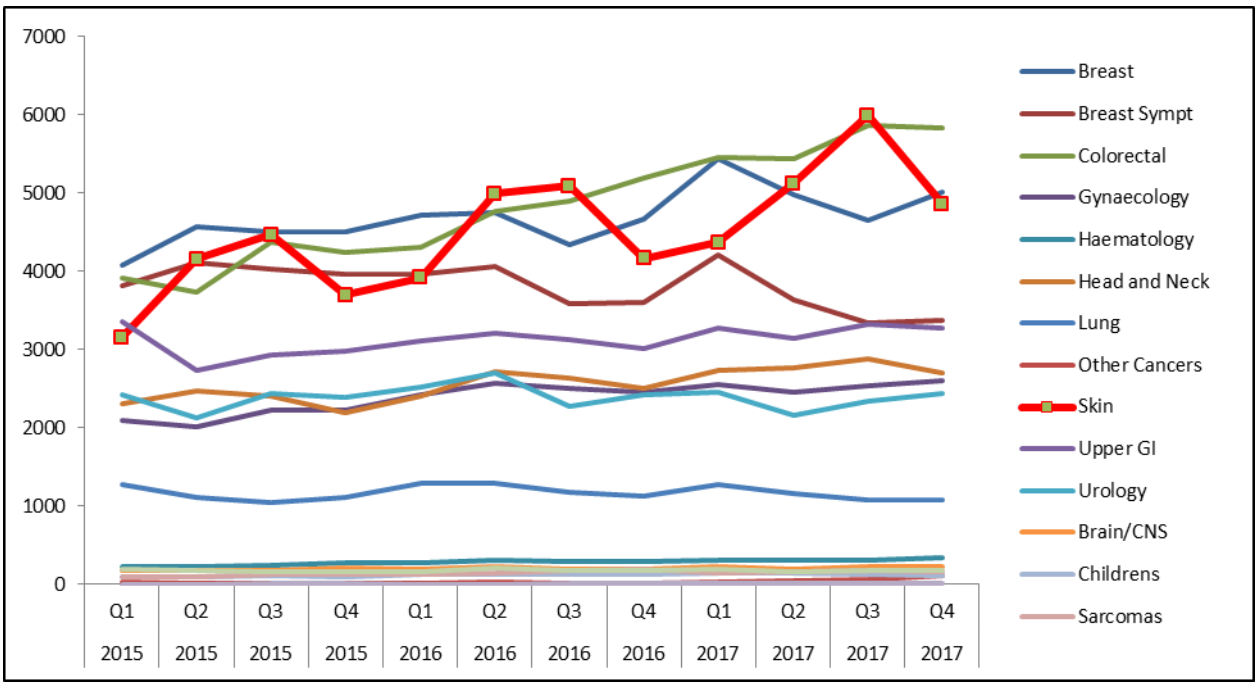

Figure 2. Number of cancer referrals 2015-2017 by quarter for all cancers in Greater Manchester and Eastern Cheshire. Data source: Open Exeter CWT.

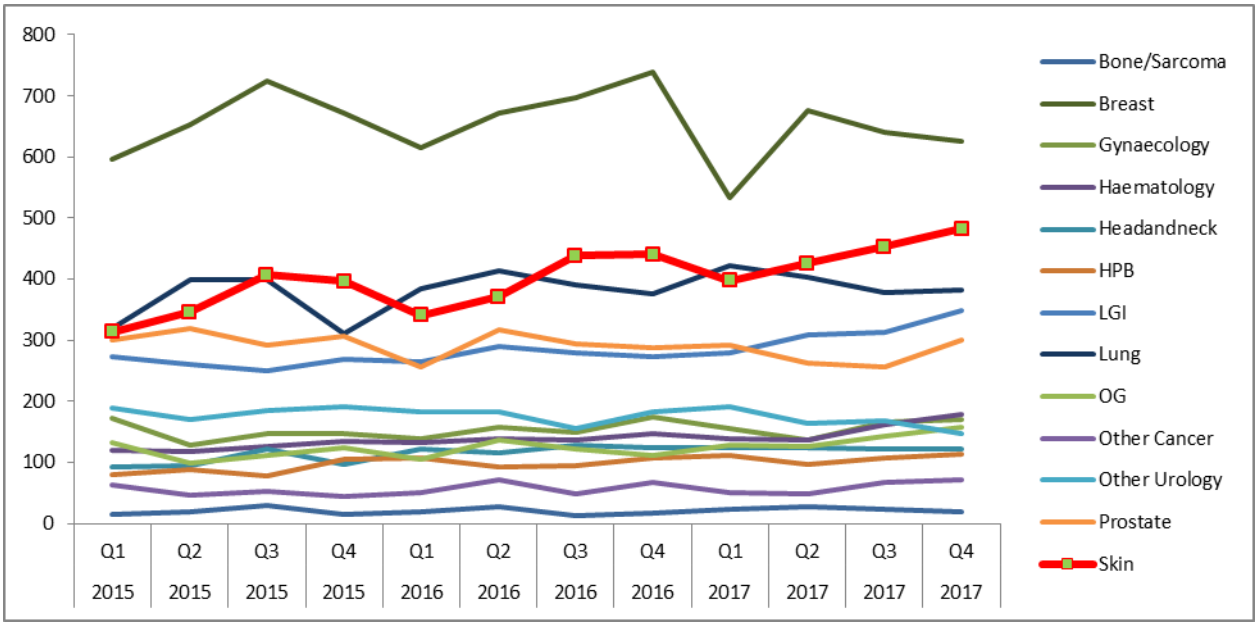

Figure 3. Number of cancer treatments 2015-2017 by quarter for all cancers in Greater Manchester and Eastern Cheshire. Data source: Open Exeter CWT.

The conversion rate for GP two week wait referrals over a five year period is 7.7% which means that 90% of GP-referred two week wait suspected skin cancer patients are found **not** to be cancerous[1]. This analysis, combined with the dramatic increase in skin cancer rates year on year against workload capacity issues indicates the need for innovation and change in this area.

1.2 Performance

In skin cancer, only suspected squamous cell carcinomas (SCCs) and melanoma are subject to the cancer two-week waiting time target – basal cell carcinomas (BCCs) are not.

The national waiting targets (Greater Manchester and Eastern Cheshire) are consistently exceeded for skin cancer:

- 14 Day Referrals to First Seen Wait – 94.7% (5 year period)
- 62 Day Referrals to First Treatment – 93.8% (5 year period)

2.0 Greater Manchester Skin Pathway Board work programme 2018/19

The Skin Cancer Pathway Board has representation from all Greater Manchester and Eastern Cheshire Trusts and disciplines that treat skin cancer, including dermatologists, plastic surgeons, oncologists, pathologists, nurses and managers. It represents the complexity of skin cancer delivery in Greater Manchester with representatives of all the local and specialist MDTs across

[1] In 2012-2017, the ratio of patients diagnosed with skin cancer, out of all patients referred for suspected skin cancer for the whole of Greater Manchester was 7.7% (6134/79,407).

Greater Manchester and Eastern Cheshire. This complexity is a particular challenge, both in the pathways for cancer delivery and the diversity amongst the skin cancer types themselves.

The Board is currently working to improve primary care representation.

Over the next 12 months, the Skin Pathway Board will be focusing on several areas detailed below:

Workstream	Rationale	Overview of plans
1. MDT reform	To enhance reliability of care; to facilitate more in depth conversations of complex patients; to remain consistently in line with national strategy. Clear pathways will result in more reliable research/ trial discussions and minimise unwarranted variation in treatment options.	Work is underway to review the work led by Chris Harrison (National Clinical Director for Cancer) and Martin Gore (Ex Medical Director of the Royal Marsden), in conjunction with the consultation exercise undertaken by the British Association of Dermatologists (BAD). The Board will develop a series of recommendations for skin cancer MDTs in Greater Manchester with related alliance guidance. The intention is to focus on the local MDT initially with plans to look at the SSMDT thereafter.
2. Supporting skin cancer referral pathways	Suspected skin cancer referral rates are increasing year on year against existing workload capacity issues. The vast majority of GP-referred two week wait suspected skin cancer patients are found not to be cancerous highlighting that the current referral process is inefficient.	The Board intends to trial a new referral process and compare it to standard care. The hypothesis is that the new referral process will reduce the number of referrals and reduce the number of in-person assessments that are needed. This will hopefully enable 'future proofing' of the two week wait secondary care service. Detail of proposed pilot outlined in Section 3 of this paper.
3. Implementation of the Macmillan Recovery Package	The full implementation of the Recovery Package throughout Greater Manchester is a key objective in the Greater Manchester Cancer Plan (Achieving World-Class Cancer Outcomes in Greater Manchester).	Macmillan Recovery Package mapping workshop undertaken mid-October 2018 with representatives from all Trusts to assess current practice in terms of implementation of the Recovery Package; identify any gaps that exist; highlight areas of good practice and formalise a plan for full roll-out within skin cancer care in Greater Manchester.
4. Research and innovation		The Board are working to increase recruitment for clinical trials.

		Work is underway to develop a melanoma database in collaboration with the Greater Manchester Cancer Data Intelligence Team.
5. Prevention of skin cancer	86% of melanoma skin cancer cases are preventable in the UK (CRUK, 2015[2]).	The Board recognises that prevention of skin cancer is pivotal to reducing prevalence of disease. It is also recognised that prevention is one of the top three priorities of Greater Manchester Cancer service users. There is no dedicated body in existence leading on skin cancer prevention in Greater Manchester and so there is potential to establish a formal working group for primary care commissioners and providers which could be supported through wider healthy living practice arrangements. There are a number of causal factors linked to skin cancer. The Board plans to review the evidence base for these causal links in collaboration with public health colleagues and look to develop a shared prevention work programme.

3.0 Supporting skin cancer referral pathways

3.1 Clinical context and economic impact

As previously stated, 80 to 90% of GP-referred two week wait suspected skin cancer patients are found not to be cancerous.[3] This is an inefficient referral process, costing the CCG £133 per

[2] https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/melanoma-skin-cancer#heading-Three

[3]In year ending 2015, the ratio of patients treated for skin cancer out of all patients referred for suspected skin cancer was 7% (44/578 referrals), 10.6% (43/148 referrals), and 29% (76/712 referrals) in three Manchester CCGs (CMCCG, NMCCG, SMCCG).

https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjo-NbaxYDcAhWLL8AKHboHAM0QFggrMAA&url=http%3A%2F%2Fwww.manchester.gov.uk%2Fdownload%2Fmeetings%2Fid%2F21524%2F6_health_cancer_services_in_manchester&usg=AOvVaw1y7MSBr9dIk8zP9uWHm0eM

patient referred. This equates to 1,275 patients needlessly making a dermatology visit, resulting in a short-term loss of £169,575 for a sample of 3 CCGs in 2015.[4] As expected, the scale of the problem increases dramatically when the total Greater Manchester footprint is considered. Assuming a consistent rate of increase in referrals and the outpatient appointment costs of £133 remains, the projected savings if 50% of non-cancer referrals were avoided would be £1,516,582.

This has a negative impact on wait-lists, reducing access to patients with an actual clinical need. The number of two week wait referrals in Greater Manchester is increasing year on year (Figure 2), putting much strain on services already struggling to meet waiting time targets.

Long wait-lists reduce the potential for cheaper early intervention and increase the likelihood of more expensive reactive interventions.

3.3 Standard care in Greater Manchester: clinical pathway

GPs refer patients to dermatologists using standard referral templates but photos are not transmitted. Upon receiving the referral, the dermatologist must assess the patient within two weeks under the suspected skin cancer pathway. Assessment is made with the patient in clinic using a dermatoscope. If melanoma is suspected, this is confirmed with a biopsy.

3.4. The intervention: Trialling an improved referral pathway

The Skin Pathway Board proposes to trial a new referral process and compare it to standard care.

The hypothesis is that the new referral process will reduce the number of referrals and reduce the number of in-person assessments that are needed. This will hopefully enable us to 'future proof' the two week wait secondary care service in Greater Manchester and Eastern Cheshire.

The new process involves triaging referrals, assisted by a digital platform that enables GPs to transmit normal photos and dermatoscopic photos to Dermatologists.

As it is a trial, the aim is to evaluate the diagnostic concordance of the new approach compared to standard care.

3.5 Methods

Approach 1, step 1: If the GP suspects the patient's lesion is skin cancer, the GP will use a smartphone app to transmit normal photos and dermatoscopic photos to the dermatologist for triage using the Medopad app. This could involve a smartphone-configured dermatoscope (potentially DermaHud, £70, to be confirmed). Each photograph includes patient notes (i.e. NHS ID, date of birth, location on body, etc.). Patients will still receive an in-person appointment with the dermatologist.

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[4] £84,588 (636 referrals), £71,022 (534 referrals), £13,965 (105 referrals).

Approach 1, step 2: Dermatologist assesses the photos prior to the patient visit and makes a diagnostic decision and management plan with the following outcomes:
(i) benign lesion, discharge back to GP
(ii) suspected malignant cancer, schedule biopsy
(iii) wait and see - discharge back to GP for follow-up monitoring and for follow up in secondary care.
(iv) the presence of newly identified cancerous lesions separate from the lesion the patient was refereed for (only applicable during the in-person examination)

Approach 2: The dermatologist assesses the patient in-person using a dermatoscope and makes a diagnostic decision and management plan (the current service model).

Approach 3: While the patient is still in clinic, the dermatologist views the dermatoscopic image on a large desktop screen and makes a third diagnostic decision and management plan.

3.6 Project size

The aim is to recruit 100 GP practices and run the study over a 6 month period to recruit over 1000 patients.

3.7 Evaluation aims and outcomes

1. Concordance of diagnostic and management decisions across the three approaches
2. Number of newly identified cancerous lesions separate from the original lesion the patient was referred with
3. Patient satisfaction, GP satisfaction, Dermatologist satisfaction

3.8 Potential benefits

For a relatively small project cost, the potential benefits are substantial and could change skin cancer services dramatically in Greater Manchester.

Potential for complete redesign of the dermatology two week wait service provision with reduction in the number of face to face referrals by up to 50%. This could result in a dramatic cost saving.

This could be key in managing the increasing number of two week wait referrals.

The trial will assess whether this approach is safe and well received by patients, GPs and Dermatologists. It will also assess the number of incidental findings of skin cancers that the patients weren't referred for, an important factor in assessing this dermatoscopic triage.

There is potential to continue the trial to assess and/or develop the role of artificial intelligence algorithms in the pathway.

There is potential to use the Medopad app for patients with skin cancer as an adjunct in clinical follow up.

3.9 Resources required

A high-level overview of the necessary resources to support this pilot is listed below:

- Full time project manager ~£40k
- Funds for the Medopad app ~£20k
- Smartphone dermatoscope connectors ~£10k

3.10 Next steps

Early engagement with primary care has been positive. Next steps will include sharing the proposal more broadly with GP forums to seek broader support from GP practices across Greater Manchester.

Identifying funding streams to secure investment for the pilot is crucial.

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NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Paper number 3

Date: Friday 2nd November 2018

Title: Increasing 62-day Referrals to providers in Greater Manchester (GM)

From: Miss Susannah Penney,

Purpose of paper

It has been recognised that there is considerable pressure within the Cancer systems in GM and this has been evidenced by failure to maintain the 62 day cancer standard across GM in late 2018. One factor identified potentially as a cause for this is the increase in 62 day cancer referrals across GM. Our cancer intelligence services at GM Cancer were asked to provide numbers of referrals, per provider, per pathway for the calendar years 2015, 2016 and 2017. The report also looked at the number of referrals, per CGG, per pathway over the same period of time.

Recommendations

To agree with the findings within the paper regarding evidence of increase referral rates in GM and ensure this piece of work is aligned with the ongoing work to ensure sustainability of the 62 day cancer standard in GM, monitored through performance and delivery at GMH&SCP.

Contact

Miss Susi Penney, Associate Medical Director, Greater Manchester Cancer

Email: Susannah.Penney@mft.nhs.uk

Increasing 62-day Referrals to providers in Greater Manchester (GM)

Background

The national cancer waiting times policy has existed since 2001 and has been monitored since 2003. A 62-day standard for the time taken from the day a GP refers a patient on a 'cancer pathway' to treatment date has been in force since 2005 with national data collection. Data is monitored and published quarterly by NHSE.

The guidance was updated in 2009 so that the start of the pathway became the date the provider received the referral, but treatment should still take place by day 62 in 85% of cases (there are a few exceptions to this – e.g. paediatrics).

In 2015 two documents were produced with the express intention of driving earlier diagnosis and thus better outcomes for cancer patients.

NICE published new guidance for primary care colleagues with clear guidance on a reduced risk threshold for referral – a shift from 5% to 3%. Modelling at the time suggested that this would increase the number of referrals from primary to secondary care but that more cancers would be diagnosed at an earlier stage.

The second publication**: Achieving world class cancer outcomes: A strategy for England 2015 – 2020** is explicit in its recommendations:

"Drive a national ambition to achieve earlier diagnosis: This will require a shift towards faster and less restrictive investigative testing, quickly responding to patients who present with symptoms, by ruling out cancer or other serious disease. We recommend setting an ambition that by 2020, 95% of patients referred for testing by a GP are definitively diagnosed with cancer, or cancer is excluded, and the result communicated to the patient, within four weeks. Delivering this will require a significant increase in diagnostic capacity, giving GPs direct access to key investigative tests, and the testing of new models which could reduce the burden and expectation on GPs."

Clearly, the net effect of this guidance was also to be an expected increase in referrals to secondary providers with the aim of diagnosing more cancers at an earlier stage. This is beginning to have its desired effect – a progress report on the cancer plan published in October 2017 stated:

"Survival rates for cancer in this country have never been higher, and overall patients report a very good experience of care. However, we know there is more we can do to ensure patients are diagnosed early and quickly and that early diagnosis has a major impact on survival. We also know that patients continue to experience variation in their access to care, and this needs to be addressed. Early diagnosis, fast diagnosis and equity of access to treatment and care are central to the National Cancer Programme and the transformation of services we want to achieve by 2020/21."

Further changes to the national cancer waiting times metrics are being introduced – a faster diagnosis standard (FDS) will be monitored from April 2019 and assist with performance management form April 2019. This states that 95% of patients will be informed whether or not they have a diagnosis of cancer by day 28 of the 62-day pathway.

In anticipation of this a number of national 'faster diagnosis pathways' have been introduced by NHSE in a number of tumour sites – prostate, colorectal and lung. Further pathways for other tumour groups are also being developed. They are based on the principles of senior clinical triage, straight to test where appropriate, one-stop clinics where appropriate and MDT by day 21 with the FDS standard of day 28 thus being achieved.

Capacity to diagnose – An analysis of diagnostic activity in England (CRUK) published March 2018 highlighted many of the issues facing providers and CCG's with this predicted increase in referrals and suggested a comprehensive review of both radiology and endoscopy capacity be undertaken as matter of urgency as even the recommended increase in funding and provision was unlikely to cover the demand for these services.

Greater Manchester and East/Mid Cheshire

Cancer pathways within our region of start and end with different providers. This, by definition, includes some patients that start in neighbouring CCG's. Cancer performance as a system is defined by the performance of all these providers as the diagnostic part of the pathway is fundamental to a streamlined experience for the patients. A system of both a breach and treatment re-allocation is defined and mandated by NHSE and used by all providers in our system. This is an important point when analysing performance by provider trust as there may be a significant difference in the pre and post re-allocated position.

New national breach reallocation guidance was brought out in 2016 and updated in February 2018 (effective in GMEC from April 2018 and monitored from Q3 2018). Historically GMEC had used a slightly different system of re-allocation, agreed with NHSE, based on the number of 3-provider pathways unique to GMEC. The new system brought a significant change to the way that both breaches and treatments would be allocated to our providers, although the overall performance of GMEC as a system would be largely unaffected. This has been proven in Q2 2018 by reporting both the new and the old system simultaneously. *(National Cancer Breach Allocation Guidance, April 2016, Addendum to the National Cancer Waiting Times Monitoring Dataset Guidance v9.0)*

However, GMEC has seen a decline in its 62-day cancer performance metric in many providers and in Q1 2018 failed the standard as a system for the first time in eight years.

2015 – 2016	Q1	85.7%	112, 491 referrals
	Q2	85.9%	
	Q3	88.5%	11 021 treatments
	Q4	86.7%	

2016 - 2017	Q1	87.3%	122, 381 referrals
	Q2	86.7%	
	Q3	87.0%	11 553 treatments
	Q4	86.3%	

2017 - 2018	Q1	85.7%	130, 123 referrals
	Q2	86.8%	
	Q3	86.5%	11, 750 treatments
	Q4	85.5%	

Figure 1: Overall 62-day referrals, treatments are irrespective of type of referral e.g. 62-day, upgrades, emergencies.

In Q1 2018 GMEC saw a marked drop in performance to 81.7% with Q2 currently running at a prediction of 80.0%. Cancer waiting times are monitored in all providers via a patient tracking list (PTL) and a cancer services team/manager who provide oversight to the administrative elements of the 62-day pathway and endeavour to ensure consistent delivery of the 62-day metric.

It can be seen that there has been a steady, but small, decline in system performance over the last three years. In January 2018 GM Cancer produced a report with recommendations for changes providers and the system could make (Clinically-led review of provider cancer waiting time processes in GMEC) following a site visit to each individual provider by a lead cancer clinician. GM Cancer also facilitated a number of system-wide events to highlight some of the issues within providers and to share learning around the management of the 62-day standard. The report (as well as a number of NHSE reports) provides guidance as to where providers may be able to improve both their cancer waiting time performance and in turn improve their patients experience.

GM Cancer is represented at the Greater Manchester Director of Operations meeting where cancer performance is regularly discussed. It was highlighted at the August 2018 meeting that many providers were simply struggling with the volume of referrals made on 62-day pathways and GM Cancer was asked to assist with the provision of data around this from their intelligence service, as well as assist with possible solutions.

Our cancer intelligence services at GM Cancer were asked to provide numbers of referrals, per provider, per pathway for the calendar years 2015, 2016 and 2017. It was though that this would provide an accurate picture as a change in the cancer waiting times monitoring system software took place in April 2018 meaning that data from Q4 2017 would be unvalidated for some time. We also looked at the number of referrals, per CGG, per pathway over the same period of time. This is different data as the CCG where the patients originate may not always correlate with where they are first seen – this can be dictated by the patient, the practice or the pathway (Not all pathways are offered by all providers e.g. breast).

The data in figure one represents the total number of referrals per year across the system on a 62-day pathway, it does not account for upgrades, and in essence shows that in three years the total number of 62-day referrals has gone up by 15.7% (an extra 17 632 patients).

Cancer pathways can also be initiated via an ‘upgrade’ system. This means that after a non-62-day referral to secondary care a clinician ascertains information that may indicate the patient has a >3% risk of cancer. These patients are also classed as suspected cancer patients and traverse the provider pathway in a similar manner to 62-day patients adding to the diagnostic workload. The dialogue below shows where some of the main increases in 62-day referrals have taken place and some of the reasons why.

Overall increases by pathway

Pathway	3-year increase
Colorectal	38.8% (6313)
Skin	31.5% (4879)
Haematology	30.8% (296)
Gynaecology	18.6% (1595)
Head and neck	18.3% (1716)
Breast	13.8% (2434)
Upper GI	8.6% (1028)
Lung	0.7% (33)
Urology	0.3% (29)

The sustained increase in numbers of patients referred on a 62-day pathway was expected given the changes in NICE guidance, the 'be clear on cancer campaigns' and media coverage of high-profile celebrities also being affected. With one in two of the population likely to be diagnosed with cancer in their lifetime and most people being affected by it in some way there is a paradigm shift in many areas to seek help earlier if worrying symptoms are exhibited. As a healthcare system we need to manage this increase proactively to ensure the continued timely management of this cohort of patients.

A further piece of work undertaken in GM by the behavioural insights team to examine patterns of referral particularly by low referring practices, and an intervention to increase their referrals has also been undertaken which may contribute to some of the more recent increases we have seen.

Below is a breakdown of the high-volume pathways along with some illustration of where the difficulties are being encountered.

Colorectal/Lower Gastrointestinal (LGI) pathway

Provider	3-year increase
Bolton	32.1% (4412)
East Cheshire	17.7% (3630)
Mid Cheshire	34.3% (4274)
Pennine	58.2% (13 903)
Salford	50.8% (3577)
Stockport	25.9% (6109)
Tameside	25.5% (5844)
WWL	62.5% (5180)
Manchester	29.8% (11 027)

The above data illustrate the increasing pressures on this particular pathway. NHSE have issued a faster diagnosis pathway for LGI cancer both as a straight-to-test and outpatient model.

The fact remains that the pathway depends heavily on endoscopy capacity (colonoscopy, flexible sigmoidoscopy) as well as radiology capacity (CT scanning, MRI scanning and CT colonography). Without timely diagnostics and workforce, the pathway cannot succeed. https://www.england.nhs.uk/wp-content/uploads/2018/04/implementing-timed-colorectal-cancer-diagnostic-pathway.pdf

Urology

Provider	3-year increase
Bolton	6.3% (2444)
East Cheshire	8.0% (1776)
Mid Cheshire	-12.1% (-109)
Pennine	0.4% (10)
Salford	-1.0% (-6)
Stockport	-6.4% (-67)
Tameside	-3.6% (-25)
WWL	15.8% (118)
Manchester	0.8% (14)

On this data the urology pathway appears to be relative stable, however, there has been a decline in its overall performance across GM in some providers. Like in LGI, a new 'best-timed pathway' has been designed for prostate cancer referrals https://www.england.nhs.uk/wp-content/uploads/2018/04/implementing-timed-prostate-cancer-diagnostic-pathway.pdf and this relies heavily on the use of mpMRI scanning early in the pathway to ensure only those with true abnormal prostates are investigated. This has the benefit of reducing the need for transrectal biopsies and the inherent risks associated with this procedure. Specialist MRI scanning for this is in short supply across GM leading to a capacity issue. In addition, specialist scanning has created an increased need for template biopsies, currently a shortage area as it is only supplied by a very limited number of providers.

Breast

Provider	3-year increase (classic)	3-year increase (symptomatic)
Bolton	38.7% (5120)	5.0% (97)
East Cheshire	21.7% (281)	13.5% (-110)
Mid Cheshire	10.9% (153)	-7.8% (-103)
Pennine	29.2% (1134)	-13.7% (-364)
Salford*	-85.7% (-1195)	-100% (-1722)
Stockport	8.4% (136)	1.0% (15)
Tameside	-16.5% (-238)	4.4% (44)
WWL	0.5% (8)	15.9% (211)
Manchester	51.9% (1642)	15.7% (566)

*Service discontinued during data period

Breast patients have been redistributed around GM following the cessation of services at Salford. Radiology workforce problems have been keenly felt in breast services across GMEC with many providers citing problems with clinical radiology support for the pathways.

The above data suggests an increase of 7041 referrals over the last three years for classic 62-day breast referrals and a reduction of 1366 in symptomatic patients – still a net increase of 5675 referrals entering the system.

(All breast patients – whether suspected cancer or not should be seen within 14 days hence 2 pathways

Lung

Provider	3-year increase
Bolton	3.2% (14)
East Cheshire	21.6% (37)
Mid Cheshire	16.3% (59)
Pennine	2.4% (36)
Salford	22.0% (57)
Stockport	8.3% (17)
Tameside	-23.7% (-111)
WWL	-32.5% (-106)
Manchester	4.1% (35)

Lung cancer is one of the biggest killers in GMEC. There have been several system-wide initiatives to assist with early diagnosis and treatment of lung cancers (lung health checks, implementation of the faster diagnosis RAPID pathway etc). In order for the providers to implement up-front radiological investigations prior to the patient being seen by a clinician many patients now come for a STT x-ray/low-dose CT and are then tracked as an upgrade through the cancer system. Variable implementation of this pathway as led to the impression of a reduction in 62-day referrals, but this is more than balanced by the number of upgrades in the system. https://www.england.nhs.uk/wp-content/uploads/2018/04/implementing-timed-lung-cancer-diagnostic-pathway.pdf

EBUS has now become the standard of care for the majority of lung cancer diagnostic pathways (rather than bronchoscopy) leading to delays in pathways as some sectors are unable to provide this as a five-day service leading to delays waiting for investigations. Biopsies now need additional testing for tumour markers before treatment can be started (PDL-1). Cardiothoracic surgery capacity also appears to be problematic for some smaller providers in terms of simply getting patient's seen and assessed for suitability for surgery prior to a definitive treatment plan being made (responsibility remains with the first trust until treatment decision made).

PET-CT is also now performed for the vast majority of these patients to assist with confirmation of cancer as well as assessment for treatment.

In addition, lung cancer patients may present with vague symptoms or be identified whilst on other cancer pathways as well as presenting as emergencies.

Gynaecology

Provider	3-year increase
Bolton	22.8% (168)
East Cheshire	14.7% (65)
Mid Cheshire	21.6% (143)
Pennine	13.6% (297)
Salford	28.6% (166)
Stockport	16.9% (147)
Tameside	12.6% (91)
WWL	44.9% (272)
Manchester	13.7% (243)

Gynaecology pathways have seen a sustained increase – this may be contributed to by the lack of a vague symptoms' pathway in many areas of GMEC. Lower abdominal symptoms can be indicative of either a gynaecological or a LGI malignancy and there is not infrequently a dual referral made. These patients often need a number of investigations to clarify their diagnosis. The increase in referrals has put pressure on the "one-stop post-menopausal bleeding clinics" which are often run single-handedly in smaller providers.

Head and Neck

Provider	3-year increase
Bolton	19.8% (140)
East Cheshire	3.7% (17)
Mid Cheshire	18.5% (127)
Pennine	16.3% (360)
Salford	26.6% (179)
Stockport	17.4% (181)
Tameside	4.9% (45)
WWL	33.1% (249)
Manchester	21.4% (412)

Many head and neck patients are managed via "one-stop clinics". About 50% will require some sort of investigation (radiological most frequently) prior to being diagnosed or stepped-down from a pathway. The head and neck cancer pathway also represents the entry-point to the providers for many suspected lymphoma patients – they too require scans and biopsies. Specialist cytology is not yet available throughout GMEC (MRI/Trafford only) this meaning that some patients require extra investigations in some other providers.

Skin

Provider	3-year increase
Bolton	17.5% (197)
East Cheshire*	-99.8% (-1056)
Mid Cheshire	28.4% (419)
Pennine	n/a
Salford	45.9% (2128)
Stockport	n/a
Tameside**	-22.8% (-593)
WWL	38.7% (581)
Manchester	45.5% (1229)

*service withdrawn during data collection

**managed service by another provider in addition to trust

Skin cancer referrals are seen by other providers in GMEC so it is difficult to ascertain how many referrals go to them (ASI Virgin Care) – they deal with Oldham skin patients (many of whom used to attend Tameside). Nevertheless, there is a large increase overall in referrals for skin cancer. This means that as all patients are seen by a dermatology service there is considerable pressure on outpatient capacity. This particular pathway also generates a large pathology workload as many patients will require a biopsy/excision as their sole investigation/treatment

Upper Gastrointestinal

Provider	**3-year increase**
Bolton	15.6% (150)
East Cheshire	-10.3% (-87)
Mid Cheshire	1.3% (9)
Pennine	8.7% (279)
Salford	8.7% (74)
Stockport	-11.2% (-145)
Tameside	5.9% (66)
WWL	16.6% (194)
Manchester	26.4% (486)

The upper GI pathway represents the most complex diagnostic pathway of any tumour site. Treatment has been consolidated at SRFT in recent months, but diagnostics remain the responsibility of the first provider trust. Patients not only require endoscopy (STT here has existed for many years) but also require CT scanning, PET-CT, EUS and a staging laparoscopy - all prior to a treatment decision being carried out. This pathway has been challenging for all providers within GMEC due to its complexity - an anticipated best practice diagnostic pathway is due out later this year from NHSE.

Haematology

Provider	**3-year increase**
Bolton	48.9% (46)
East Cheshire	n/a
Mid Cheshire	38.8% (26)
Pennine	48.2% (121)
Salford	n/a
Stockport	41.7% (30)
Tameside	27.5% (14)
WWL	46.0% (29)
Manchester	12.0% (30)

Although not a high-volume pathway, haematology patients are usually diagnosed by a biopsy from the parent surgical speciality e.g. neck lumps are often first seen by head and neck surgeons. The data above simply illustrates those that started out on a 62-day pathway within haematology.

Many more patients will form part of the referral data for other surgical disciplines making the real increase harder to calculate. With treatments being up 13.4% it can be clearly seen that we are seeing and diagnosing many more haematology patients.

Summary

The data above covers the more common and high-volume referral pathways. Other pathways; brain/CNS (19%), acute leukaemia (figures too small to be relevant), children's (39.4%) and sarcomas (21.3) and have also all seen a sustained increase in referrals.

Assistance with implementation of the lung, prostate and colorectal best practice pathways is being co-ordinated by GM Cancer with transformation funding, commencing in Jan 2019. This will assist with streamlining these patient pathways. It will not reduce the demand on diagnostic infrastructure such as radiology and endoscopy as the investigations are embedded within the pathway – they just take place at an earlier point in time.

Many providers have cited problems with poor quality or 'inappropriate' referrals. This can lead to patients not being seen in the correct speciality at the start of their pathways leading to delays in diagnosis. The GM cancer education platform, Gateway C, is specifically developing a module for primary care on 'how to write a good cancer referral'. With respect to inappropriate referrals – GM cancer is currently undertaking an audit across the system to try to obtain data around whether the referrals are truly inappropriate or just poorly written.

A further supplement to this report with comments on 31-day upgrades will be circulated once the data is available.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Paper number 4

Date: 2nd November 2018

Title: Single Surgery Cancer Models – Programme Implementation Update-presentation

From: NHS Transformation Unit

Purpose of paper

The presentation attached sets out a progress update on the implementation of the new cancer surgery services for Oesophageal, Gynaecology and Urology.

Recommendations

The GM Cancer Board is asked to provide their feedback on the update and also provide any specific advice they have re service branding.

Contact:

Sarah Maynard Walker, Programme Director, NHS Transformation Unit
Sarah.maynardwalker@nhs.net

Kate Rogerson, Senior Project Manager, NHS Transformation Unit
kate.rogerson@nhs.net

Greater Manchester Cancer Board

Paper number 5

Date: 2nd November 2018

Title: Report of Deep Inferior Epigastric Perforator Artery (DIEP) breast surgical services in Wythenshawe Hospital.

From: Manchester Foundation Trust (MFT)

Purpose of paper

The purpose of this report is to provide the GM Cancer Board with a summary of the actions taken in response to demand and capacity constraints at Wythenshawe Hospital for the Deep Inferior Epigastric Perforator (DIEP) Flap service.

Recommendations

To agree with the conclusions in the report and assurance given regarding actions taken to deal with current demand and capacity constraints evidenced across GM.

Contact Details

Rachel Bayley, Director of Performance and Resilience

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Manchester University NHS Foundation Trust

Deep Inferior Epigastric Perforator (DIEP) Flap service

October 2018

Authors:

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Michelle Irvine, Director of Performance and Quality Improvement MHCC

INTRODUCTION

The purpose of this report is to provide the GM Cancer Board with a summary of the actions taken in response to demand and capacity constraints at Wythenshawe Hospital for the Deep Inferior Epigastric Perforator (DIEP) Flap service.

SUMMARY OF THE SERVICE

MFT is one of five centres nationally that offer a DIEP service, with 3 plastic surgeons who specialise in this procedure. DIEP is one type of breast reconstruction available along with implant and autologous. DIEP procedures take the form of immediate procedures i.e. a mastectomy and reconstruction at the same time, or delayed with the reconstruction typically 12 months post mastectomy. Procedures may be unilateral or bilateral, with a significant amount of resource required in order to undertake bilateral procedures.

In addition to patients on a cancer pathway, reconstructions are undertaken for patients with the BRAC1 gene as high risk of developing cancer via the Family History service. This cohort of patients is placing significant demand on the DIEP service due to growth in referrals and because mastectomies are undertaken bilaterally.

Clinical Benefits of DIEP - Unlike implant based reconstructions, DIEPs do not require ongoing maintenance or surgical revisions for the life of a patient which reduces/ avoids rupture of implants, reduces restricted mobility due to muscle damage and other associated complications. As this technique uses the patient's own body tissue, it results in a more natural aesthetic appearance. Under NICE guidance, patients should be offered all options for reconstruction, either delayed or immediate, unless clinically not appropriate.

DEMAND & WAITING LIST POSITION

- GM 10% growth for Breast services over the last 10 years.
- The below table demonstrates significant growth in the waiting list which has nearly doubled over the last three years.
- In 2017/18 78% of the additions were unilateral procedures, and 22% bilateral.
- Circa 35% of the waiting list are referrals from outside of GM.
- As at 15th October 2018, there are 105 patients on the admitted waiting list for a DIEP procedure.
- As demonstrated from the below data the service has been experiencing long waits for the delayed reconstructions and breaches of the 52 week standard have occurred.

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
DIEP additions to the waiting list	**16**	**71**	**48**	**42**	**68**	**87**	**124**	**146**
% growth	-	344%	-32%	-13%	62%	28%	43%	18%

52-week breaches

- Performance as at September is now in line with the recovery trajectory.

	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18
DIEP/ Consequential DIEP-related procedures	16	24	25	25	25	30	31	28	32	32	30	26
Other	1	0	0	0	0	1	1	1	1	0	0	0
Total	**17**	**24**	**25**	**25**	**25**	**31**	**32**	**29**	**33**	**32**	**30**	**26**

No. of 52-week waits	Apr-18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar-19
DIEP Recovery Trajectory	30	28	25	27	27	26	24	22	19	17	17	15

RECOVERY ACTIONS AND TRAJECTORY

Timeline

07/11/17	A meeting was held with Commissioners and the Wythenshawe clinical and managerial team to discuss the service, future options and income for the service, which at that time did not cover the costs of the service.
Mid November	Discussions within MHCC regarding funding options to enable development of a business case to increase capacity.
13/12/17	Commissioning meeting to agree further steps.
End of November	Confirmed income arrangements for the service.
March 2018	Recovery trajectory in line with national requirements to reduce +52 week breaches agreed with MHCC and NHSI as part of the MFT 2018/19 operational plans, see below.
April 2018	DIEP Business case developed and approved.
June 2018	MHCC agreement to restrict access to the DIEP service.
18/06/18	Communication to CCGs, GPs to advise of temporary service changes *(Appendices A & B)*, with restrictions to the service in place from this date. MFT has not accepted referrals outside the clinical criteria from this date.

Key Actions:

- Management of risk and safety has been a key priority with clinical validation and risk stratification of all risk-reducing referrals (i.e. patients with the BRAC1 gene) with subsequent patient discussions to discuss condition and treatment options.
- Discussions and agreement with MHCC to temporarily restrict the service.
- Development of a clinical protocol set out in *Appendices A & B*.
- Outsourcing of other breast procedures in order to create additional internal capacity for DIEPs.
- Additional waiting list sessions undertaken at MFT to increase short-term capacity, whilst the business case is developed and implemented.
- MFT contacted other DIEP centres to determine if activity can be transferred; this was not an option due to capacity pressures within the other centres.
- Business case developed and approved to increase workforce and capacity. Subsequent recruitment has taken place with two additional consultants who will commence in post in December 2018 and March 2019.
- Communication undertaken through MHCC as noted above and in *Appendices A & B*.
- Recovery trajectory in place - the above trajectory assumed restriction of the service from April 2018, although in practice this did not take place until June 2018 in line with the communications to all parties. The trajectory delivers the national requirement to reduce breaches by half by March 2019, although all efforts are being made to reduce this further. Whilst performance in Q1 was out with the trajectory this has since come in line from September.
- Regular joint review and oversight continues with ongoing governance arrangements are outlined in *Appendix A*.

CONCLUSION

In summary, the restriction of the service has been required in order to manage the demand whilst additional capacity can be put in place to tackle the current waiting times, reduce the waiting list, and provides future proofing of the service to ensure demand and capacity are aligned. The paper outlines the actions being taken with progress already made to increase the workforce and reduce the 52 week waits in line with the national requirements.

A review will be undertaken in Q4 to inform the 2019-20 commissioning arrangements and contract. Consideration will be given to the potential to expand the clinical criteria and timescales for delivery of a sustainable service. The outcomes of which will be shared with Co-Commissioners and the GM Cancer Board.

As noted above MFT explored opportunities to transfer activity to the other DIEP centres in order to secure additional capacity, however due to capacity constraints these providers were not in a position to accept additional activity. Subsequently, The Christie has indicated they have capacity and could undertake circa 20 DIEP cases per year, this is currently subject to discussion with Commissioners.

Appendix A - Temporary Closure to Delayed DIEP Referrals at Manchester Foundation Trust (Wythenshawe Hospital)

Manchester Health & Care Commissioning
A partnership between Manchester City Council and NHS Manchester CCG

MANCHESTER CITY COUNCIL

NHS Manchester Clinical Commissioning Group

2nd Floor, Parkway 3

Parkway Business Park

Princess Road

Manchester

M14 7LU

Tel: 0161 765 4001

18th June 2018

Dear CCG Commissioning Representative for the MFT Contract

Re: Temporary Closure to Delayed DIEP Referrals at Manchester Foundation Trust (Wythenshawe Hospital)

An exponential growth in demand for the highly-specialised DIEP (deep inferior epigastric perforator) flap reconstructive surgery procedure at Wythenshawe Hospital (part of Manchester University NHS FT) has resulted in patients waiting in excess of 50 weeks (and in some cases over 52 weeks) for treatment. Manchester Health and Care Commissioning (MHCC) have therefore agreed for the Trust to put the following restrictions in place for a period of 12 months (reviewed on a monthly basis):-

- Full closure to all unilateral and bilateral delayed DIEP reconstruction referrals – this relates to those patients who have previously had a mastectomy and have now opted for a DIEP reconstruction procedure
- Immediate DIEP reconstruction will only be offered as a procedure of choice to women who meet strict clinical criteria and are assessed in the weekly Oncoplastic MDT as unsuitable for other immediate reconstruction surgery. Patients for whom this will be applicable are those who have had previous radiotherapy for breast cancer or part of Hodgkin's disease, suitable BMI and no medical or surgical contradictions or chest wall deformities that make LD flap or implants unsuitable.

All patients currently on the waiting list will be managed in chronological order to ensure those women who have been waiting the longest are treated as soon as possible. The Trust's aim is to eliminate the number of over 52 week waiters as soon as possible.

Governance Arrangements

In order to develop a sustainable future service model the Trust has developed a recovery plan; progress against which will be reviewed with MHCC on a fortnightly basis, along with relevant waiting list information. In addition the Trust has:-

- undertaken extensive demand and capacity modelling to better understand the infrastructure requirements moving forward to ensure women are seen and treated in this service within national waiting time standards;
- approved a business case for two additional DIEP/ Plastic Surgery Consultants and supporting infrastructure;
- established a DIEP Improvement Group to oversee the implementation of the business case and recovery plan
- clinically validated all women who have waited in excess of 52 weeks offered alternative surgery;
- agreed for patients to be offered an alternative DIEP surgeon where their waiting times are shorter.

Fortnightly assurance meetings are being held with representatives for the Lead CCG (NHS Manchester) and performance is reported to CCGs at the monthly (formal) Finance & Performance meeting. This position will be reviewed after 6 months to better understand the plan moving forward.

If you have any questions, please do not hesitate to get in touch with darren.wagstaff@nhs.net at NHS Manchester CCG.

We apologise for the inconvenience this may cause and ask that could you ensure that their respective Provider organisations are made aware of these changes which also apply to any tertiary referrals made into Wythenshawe/MFT service.

Yours sincerely

Michelle Irvine

Director of Performance and Quality Improvement

Manchester Health and Care Commission

Appendix B - Temporary Changes to Commissioning Intentions for DIEP (deep inferior epigastric perforator) Flap Reconstruction Surgery at Manchester University NHS FT (Wythenshawe Site)

Background

The Nightingale Centre and Prevention Breast Unit within Manchester University Foundation Trust (MFT) is Europe's first purpose built breast cancer prevention and treatment facility and is a leading Breast Cancer Institute within a national and international reputation. It serves Trafford, Manchester and Salford regions as well as providing tertiary services to a large demographic population, diagnosing circa 900 breast cancers per year, making it the largest single breast site in the UK. The service is supported by ten Breast Surgeons, the majority of which have national fellowships in oncoplastic breast surgery, enabling the unit to offer patients a wide range of surgical options following diagnosis of breast cancer or familial breast cancer, in line with NICE guidance.

Breast teams across the region work closely with our three Consultant Plastic Surgeons at Wythenshawe Hospital (part of Manchester University NHS FT) who are able to offer a high quality deep inferior epigastric perforator (DIEP) procedure if clinically suitable, which are only offered by specialised centres. MFT is therefore the only local provider to offer DIEP reconstruction.

There are three cohorts of patients, which are as follows:-

i. Symptomatic- patients diagnosed with breast cancer who are suitable for an immediate unilateral/bilateral DIEP flap reconstruction and will be treated in line with the cancer pathway
ii. Family History – diagnosis of either BRCA gene carrier or 1 in 3 lifetime risk of developing breast cancer and opt for an immediate mastectomy procedure with DIEP reconstruction
iii. Patients who have previously had a mastectomy and have now opted for a delayed DIEP reconstruction procedure

The demand for the highly-specialised DIEP flap reconstructive surgery procedure at Wythenshawe Hospital and capacity constraints has resulted in patients waiting in excess of 50 weeks (and in some cases over 52 weeks) for treatment. Manchester Health and Care Commissioning have therefore agreed for the following arrangements to be put in place for a period of 12 months (reviewed on a monthly basis):-

- Full closure to all unilateral and bilateral delayed DIEP reconstruction referrals for all CCGs. Patients will be offered an alternative reconstruction procedures which can be undertaken by our breast surgeons or plastic surgeons
- Full closure to all immediate DIEP reconstruction for all CCGs outside the host and associate CCGs

- Immediate DIEP reconstruction for women within Greater Manchester and associate CCGs will only be offered as a procedure of choice to those who meet strict clinical criteria and are assessed in the weekly Oncoplastic MDT as unsuitable for other immediate reconstruction surgery. Patients for whom this will be applicable are those who have had previous radiotherapy for breast cancer or part of Hodgkin's disease, suitable BMI and no medical or surgical contradictions or chest wall deformities that make LD flap or implants unsuitable.

All patients currently on the waiting list will be managed in chronological order to ensure those women who have been waiting the longest are treated as soon as possible. The Trust's aim is to eliminate 52 week waiters as soon as possible.

Governance Arrangements

In order to develop a sustainable future service model the Trust have a recovery plan which will be monitored by MHCC on a fortnightly basis, along with waiting list profile. In addition the Trust has:-

- undertaken extensive demand and capacity modelling to better understand the infrastructure requirements moving forward to ensure women are seen and treated in this service within national waiting time standards;
- approved a business case for two additional DIEP/Plastic Surgery Consultants and supporting infrastructure;
- established a DIEP Improvement Group to oversee the implementation of the business case and recovery plan
- clinically validated all women who have waited in excess of 52 weeks and offered alternative surgery;
- agreed for patients to be offered an alternative DIEP surgeon where their waiting list is shorter.

Fortnightly assurance meetings are held with representatives for the Lead CCG (NHS Manchester) and performance is reported to CCGs at the monthly (formal) Finance & Performance meeting. This position will be reviewed after 6 months to better understand the plan moving forward.

If you have any questions, please do not hesitate to get in touch with darren.wagstaff@nhs.net at NHS Manchester CCG.