GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Lung Pathway Board

Lung Pathway Board Meeting
Minutes and Actions

Friday 24th May 2019 11:00-13:00

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

Members in attendance			
Name	**Role**	**Organisation/Representation**	**Attendance 2019/20**
Matthew Evison (ME)	Chair/Clinical Pathway Director		1/1
Rachel Allen (RA)	Pathway Manager	GM Cancer	1/1
John Shuttleworth (JS)	Patient Representative	User Involvement	1/1
Nic Clews (NC)	Patient Representative	User Involvement	1/1
Paula Daley (PD)	User Involvement Manager	GM Cancer	1/1
Simon Bailey (SB)	Chest Physician	Manchester NHS Foundation Trust (Oxford Road) **– Trust representative**	1/1
Haval Balata (HB)	Respiratory Physician	Manchester NHS Foundation Trust (Wythenshawe) **– Trust representative**	1/1
Duncan Fullerton (DF)	Respiratory Physician	Mid Cheshire Hospitals NHS Foundation Trust **– Trust representative**	1/1
Louise Brown (LB)	Consultant in Respiratory Medicine	Pennine Acute Trust **– Trust representative**	1/1
Seamus Grundy (SG)	Consultant Respiratory Physician	Salford Royal NHS Foundation Trust **– Trust representative**	1/1
Suman Das (SD)	Consultant in Respiratory Medicine	Stockport NHS Foundation Trust **– Trust representative**	1/1
Praveen Bhatia (PB)	Chest Physician	Tameside Hospital NHS Foundation Trust **– Trust representative**	1/1
Haider Al-Najjar (HAN)	Chest Physician	Manchester NHS Foundation Trust (Oxford Road)	1/1
Felice Granato (FG)	Thoracic Surgeon	Manchester NHS Foundation Trust	1/1
Kandadai Rammohan (KR)	Thoracic Surgeon	Manchester NHS Foundation Trust	1/1
Durgesh Rana (DR)	Consultant Cytopathologist	Manchester NHS Foundation Trust	1/1
Mayuri Basnet (MB)	Consultant Histopathologist – Cellular Pathology	Wrightington, Wigan & Leigh/Salford Royal NHS Foundation Trusts	1/1
Emma Halkyard (EH)	Nurse Clinician – Lung Cancer	The Christie NHS Foundation Trust	1/1
Karen Clayton (KC)	Lung Clinical Nurse	East Cheshire NHS Foundation	1/1

	Specialist Lead	Trust **– Trust representative (deputising)**	
Kathryn Slater (KS)	Lung Cancer Specialist Nurse	Bolton Foundation Trust	1/1
Carol Farran (CF)	Macmillan Lung Cancer Specialist Nurse	Stockport NHS Foundation Trust	1/1
Anna Sharman (AS)	Lead Radiologist	Manchester NHS Foundation Trust	1/1
Ben Taylor (BT)	Consultant Radiologist	The Christie NHS Foundation Trust	1/1
Carolyn Allen (CA)	Consultant Radiologist	Pennine Acute Trust	1/1
David Woolf (DW)	Consultant Clinical Oncologist	The Christie NHS Foundation Trust	1/1
Fiona Blackhall (FB)	Medical Oncology Lead	The Christie NHS Foundation Trust	1/1
Coral Higgins (CH)	Senior Cancer Programme Manager	GM Cancer Commissioning Manager Representative	1/1
Janet Smart (JS)	Cancer Manager	Cancer Manager Representative	1/1
Del Wray (DW)	Lung Best Timed Pathway Project Manager	GM Cancer	1/1
Freya Howle (FH)	CURE Project Manager	GM Cancer	1/1
Venencia Sibanda (VS)	Lung Clinical Nurse Specialist	Wrightington, Wigan & Leigh NHS Foundation Trust **– Trust representative (deputising)**	1/1

Guests in attendance		
Name	**Role**	**Organisation**
Ali Lewin (AL)	Associate Director of Commissioning	GM Cancer
Alison Armstrong (AA)	Programme Lead	GM Cancer
Cathryn Winchcombe (CW)	Directorate Manager, Respiratory	Tameside Hospital NHS Foundation Trust
Jane Cronin (JC)	User Involvement	Macmillan User Involvement/GM Cancer
Kathryn Groom (KC)	CURE Project Manager	GM Cancer
Ryan Moore (RM)	CURE Project Manager	GM Cancer
Zahra Batool (ZB)	Senior Team Administrator	GM Cancer
Zoe Merchant (ZM)	Prehab Project Manager	GM Cancer

Apologies			
Name	**Role**	**Organisation**	**Attendance 2019/20**
Anna Walsham (AW)	Lead Radiologist	Salford Royal Foundation Trust	0/1
Carol Diver (CD)	Macmillan Cancer Nurse Consultant	Tameside Hospital NHS Foundation Trust	0/1
Eustace Fontaine (EF)	Thoracic Surgeon	Manchester University NHS Foundation Trust	0/1

Ian Webster (IW)	Consultant in Respiratory Medicine	Bolton NHS Foundation Trust **– Trust representative**	0/1
Jackie Fenemore (JF)	Lung Cancer Nurse Clinician	The Christie NHS Foundation Trust	0/1
James Whittaker (JW)	Consultant Radiologist	Stockport NHS Foundation Trust	0/1
Jane Weir (JW)	Macmillan Advanced Nurse Practitioner	Pennine Acute Hospitals NHS Trust	0/1
Jayne Holme (JH)	Consultant Respiratory Physician	Manchester University NHS Foundation Trust	0/1
Joanna Gallagher (JG)	Consultant in Respiratory Medicine	East Cheshire NHS Trust **– Trust representative**	0/1
Kath Hewitt (KH)	Specialist Thoracic Nursing Lead	Manchester University NHS Foundation Trust	0/1
Kathryn Place (KP)	Macmillan Transformation Manager: Recovery package implementation	Macmillan	0/1
Leena Joseph (LJ)	Consultant Histopathologist	Manchester University NHS Foundation Trust	0/1
Liam Hosie (LH)	Lead Cancer GP		0/1
Nyla Nasir (NN)	Consultant Histopathologist	Mid Cheshire Hospitals NHS Foundation Trust	0/1
Phil Barber (PB)	Consultant Respiratory Physician	Manchester University NHS Foundation Trust	0/1
Rajesh Shah (RS)	Consultant Thoracic Surgeon	Manchester University NHS Foundation Trust	0/1
Ram Sundar (RS)	Chest Physician	WWL NHS Foundation Trust	0/1
Thapas Nagarajan (TN)	Consultant in Respiratory Medicine	East Cheshire NHS Trust	0/1

1. Welcome, introductions & updates	
Discussion summary	ME welcomed board members and guests to the meeting, noting apologies. It was highlighted that the Pathway Board is expanding rapidly due to the growth of GM Cancer and this will mean a change in structure. Dave Shackley has been appointed as the senior responsible officer (SRO) for cancer by Jon Rouse for GM and now has operational responsibility for the 62 day pathway performance. This is a new approach as 62 day performance has previously been individual trust's responsibility. The Alliance will now be held to account for cancer performance. An overview of the Pathway Board and GM Cancer governance was provided. ME highlighted the opportunity to highlight the Boards key objectives, key barriers and a vision for lung cancer services to take through the new governance arrangements. ***a) Sub-committee Plans*** ME emphasised the importance of the subgroups and highlighted that user

	involvement will be a key feature of these. The importance of representation from all trusts and disciplines in each of the four subgroups was noted, including a call for greater CNS and clinical involvement. The subgroup chairs are tasked with defining the memberships of these groups. Sub-groups are also tasked with identifying key challenges and objectives, which will be presented at the next Pathway Board meeting in September. Some key changes within the Board structure were announced: Richard Booton (RB) has stepped down as chair of the Optimal Diagnostics Sub-committee and South Sector lead; Seamus Grundy (SG) has been appointed as the new lead of this sub-committee. A co-chair will also be appointed soon. Duncan Fullerton (DF) has been appointed as the South Sector lead. Carol Diver (CD) has stepped down as Chair of the Living With & Beyond sub-group and so the sub-committee will be led by Emma Halkyard (EH) and Karen Clayton (KC). The Tobacco Control sub-committee are considering becoming a clinical tobacco network representing a number of bodies around the region including Making Smoking History, the GM Respiratory Network and our clinical GM Cancer Lung Pathway Board. ***b) Transformation Funding*** A second round of Transformation Funding will be likely in the near future. Proposals are being collated for prospective projects. It was noted that Lung is a priority for GM Cancer. ME will be in dialogue with the chairs of each of the four sub-committees around ideas for potential future projects that are put forward.
Actions and responsibility	**a) Board members are invited to share project ideas for Transformation Fund Round 2 with sub-committee chairs.** **b) Sub-groups to present their work plans including main objectives and key challenges at the next board meeting in September.**

2. Minutes of the last meeting (25/02/19)	
Discussion summary	Minutes of the last meeting (25th February 2019) were approved and accepted. ***a) Action Log*** The action log will be updated as sub-committee work plans are developed. No other matters arising.
Actions and responsibility	No further actions.

3. Transformation Project: GM Optimal Lung Cancer Pathway	
Discussion summary	SG was invited to present an update on the Transformation Project Optimal Lung Cancer Pathway. The main focus of the project over two years is to move towards the national optimal pathway in the first year and the optimal 28 day GM optimal pathway in the second year (by 2021). The approximate budget for this project is around £1.3 million which is based on a gap analysis undertaken through the sectors in 2018. Bids have been received from all sector MDTs, surgical centres and the Christie. The next

	steps are to undertake an in-depth review of all the bids and allocate funding based on specific criteria, evaluating the impact that each specific proposal will have. At the end of June, SG will take the project budget overview to the GM Cancer Assurance Board for their scrutiny and approval. SG clarified that the gap analysis undertaken in 2018 did not focus on the 28 day target – it looked more at national guidance and staffing levels so it is likely that the funding will not impact greatly on the 28 day pathway. SG highlighted that the funding needs to be spent by the end of 2021 and that there will be no more funding available until a new proposal to GM Cancer is made. It was noted that gold standards will be developed in relation to the 28 day pathway through the Diagnostics Sub-Committee. These will help influence at a commissioner level. SG was invited to share an overview of the daily clinician-led review in place at Salford Royal Foundation Trust as an area of best-practice. SG described the web-based software which is currently in use in Salford to record each patient who needs a CT scan and those who have suspicious CT scans. The logistics of the software were briefly explained and it was highlighted that Salford's approach could be transferable to other Trusts as a useful and crucial resource to improving the diagnostic pathway across other trusts. SG highlighted that the process of having a clinician with job-planned timed to work virtually to review the cases on a daily basis is critical to improving the diagnostic pathways. AA queried the time commitment in terms of job planning. SG suggested 1 hour a day which would be caseload dependent.
Actions and responsibility	**a) SG to present budget proposal to GM Cancer Assurance Board in June 2019.** **b) SG to explore whether the Sharepoint system/software in place at Salford could be shared with other sites/trusts.** **c) RA to share SG's Sharepoint presentation as a useful resource to influence job plans in other trusts.**

4. Thoracic Surgery Pathway Work Plan	
Discussion summary	KR presented on behalf of the six thoracic surgeons at Wythenshawe Hospital and the work that has been developed in relation to RAPID surgery which focuses on getting patients through the system efficiently. The main principles are quick intervention and a standardisation of how referrals are tackled. Currently RAPID is in use at Wythenshawe and the main advantages are: - It is a shorter pathway - Improves patient experience / overall quality of the pathway - Improves outcomes - Improves communication - Improves resection rate - Improves compliance with National 31, 62 day targets across Manchester - Improves 24 day compliance for a 2 centre pathway - Minimises variation in practice by standardising assessments - Addresses non-cancer pathway as well

	These aspects are important in relation to measuring success. The RAPID service for surgery is slightly different to the RAPID in medicine in that the department of six surgeons will be looking after the entire 3.2 million catchment surgical referrals coming in. Wythenshawe is the largest thoracic surgery centre in the country. The algorithms were referenced. KR summarised that the ambition is to accelerate the pathway, improve patient experience and ultimately improve patient outcomes for all patients undergoing lung cancer surgery in GM. Discussions around the challenges in terms of logistics of the shuttle walk test ensued. Space required to carry out the shuttle walk test is a concern for many trusts. LB commented that through funding, some Macmillan staff have been upskilled at Pennine to help deliver the shuttle walk test and it is incorporated into the clinics. The concept of performing such tests in a public corridor was raised. The Prehab4Cancer service was suggested as a means of carrying out the 6 minute walk test (via the leisure centres) (and shuttle walk test in the future), however it was noted that not all patients meet the criteria for referral to Prehab. ME informed the Board that the 6 minute walk test in the triage referral are considered the accepted functional test. Ideally the intention is for clinicians to be working towards the shuttle walk test. It was noted that the shuttle system at Wythenshawe is at full capacity. DF highlighted that it would be helpful to understand how other sites are dealing with the challenges. A discussion ensued on the complex stage 3 group and whether some of the surgical work-up can be completed up front. FB noted that usually after radiotherapy, lung function has declined a little more. KR commented that the complex stage 3 group may require more stringent criteria. It was noted that Board need to review lung function tests that are being undertaken at Wythenshawe and other trusts across the region. The Board is aware that a proportion of tests are being repeated and there are differences in results. FG is developing a database containing 12 months' worth of data which will be presented to the Pathway Board in September.
Actions and responsibility	**a) FG to present findings of database in relation to repeat testing of lung function tests to the Pathway Board in September.**

5. Oncology Pathway Work Plan	
Discussion summary	DW highlighted the progress made in oncology and noted that recruitment for a Pathway Navigator at The Christie is underway. The concept of seeing patients locally and at home remains the same but the ambition is to see patients within a working week. This means that patients may need to be shuffled around the network into available treatment slots and so a Navigator role will be useful to help this process. There has been a change nationally/internationally in therapy protocols and work is being done to bring these protocols up to date.

	Access to quicker palliative radiotherapy is another priority workstream which needs to be a centralised process to help patient experience as it means patients can be taken out of an outpatient setting creating greater central capacity. It was noted that a proposal for SABR radiotherapy has been submitted to SG and DW as part of the Optimal Pathway Transformation project. DW updated the Board on the Optimal Treatment sub-group which has not sat formally for 12 months and so needs to be re-invigorated in a different form than before. The refreshed sub-committee will include a wider membership than treating clinicians alone. The sub-group will need to finalise its main aims and objectives in the next few months. Discussions ensued around the topic of patients declining treatment due to travelling restrictions, lack of resources and unemployment. The Board agreed that an audit needs to take place to ensure patients have equity of access to treatment. Work is being undertaken to explore the ability to deliver therapy locally under the supervision of oncologists. NC noted the Christie patient travel service.
Actions and responsibility	**a) Optimal Treatment Sub-group's work to be added to the next meeting agenda (in line with the other three sub-committees).** **b) DF to share data around patient's equity of access with the Christie team for further discussion. Optimal Treatment Sub-group to look into this.**

6. 2019 NICE Guidelines – Brain Imaging	
Discussion summary	ME presented an update on the published 2019 NICE Guidelines. The purpose of the agenda item is to discuss the Board's views on the guidelines and the challenges that the guidelines may present. It was noted that there is only a small group where the NICE guideline group undertook an evidence review and altered recommendations. The two areas for discussion are brain imaging and the N2 group. The diagnostic recommendations have been altered which supports the algorithms that the Board has already ratified for GM and Eastern Cheshire. ME highlighted the defined group requiring staging EBUS (nodes higher than 10mm) should be picked up in MDTs. Brain imaging recommendations are stipulated within NICE recommendations as follows: • Clinical Stage 1 - are not offered brain imaging unless neurological symptoms are present • Clinical Stage 2 - patients have a contrast enhanced CT brain if positive, patient to have MR Brain • Clincial Stage 3 - patients should have an enhanced MR brain ME reiterated that the guidelines should now be in operation as they are national guidelines. Alongside the recommendations, there are publications of the evidence reviews so the rationale for why the recommendations have been made is available. NICE have developed a model to explore a cost-effective analysis by grouping patients into three cohorts with varying stages of metastases. It is likely to be cost-effective to have a CT scan first at stage

	2. . It is highly cost-effective to perform a contrast-enhanced MR at stage 3. The diagnostic algorithms have been shared with Board members. The Board discussed the impact of the recommendations. The concept of an MR review with all trusts contributing was discussed. ME noted the possibility of identifying a registrar to lead the exercise.
Actions and responsibility	**a) ALL to communicate discussion on Brain Imaging and 2019 NICE Guidelines back to MDTs and Trusts.**

7. Resectable Stage III-N2 Protocol	
Discussion summary	Paper 4 was presented by ME which highlights a summary of the challenges around the Resectable Stage III-N2 Protocol. ME highlighted the need to tackle this particular issue as a board from a logistical point of view. DF and HAN commented on the challenges including logistics of the MDT with minimal delay to the patients. FB informed the board of an agreed standard system used in Toronto. FB spoke of the need for agreed standards in GM which need to be incorporated at MDT and is happy to facilitate an agreement across the region. The Pioneer Study led by ME will be crucial in having conversations with patients about the concept of being randomised to surgery or not. This will be a challenging study but crucially important. Discussions ensued around different types of modality treatments and what works best for patients. ME summarised the main outcomes from the agenda item discussions as follows: - Plans have been agreed as to how to address the challenges of implementing the Resectable Stage III-N2 Protocol going forward. - For the immediate future within MDTs, if there is a single station N2 disease, GM practice has been surgery and adjuvant chemotherapy which can continue if the patient is operable and the patient wishes. - If the patient has multiple station N2 disease and it is felt to be resectable, the patient is dual-referred to an oncology team and surgeon and the patient is informed of their treatment options. - For the time-being, this is something that the Board should encourage MDTs to follow pending how the Board then sets up tri-modality treatment. - The definition of “Resectable” agreed by the surgical team is to be shared with all board members for MDTs to use as a reference. - The current standard of single station MDT will continue. - This will be developed to include tri-modality.
Actions and	**a) FB to establish and lead a task and finish group to discuss local operating**

responsibility	**guidance (surgery, radiotherapy etc) in relation to the Resectable Stage III-N2 Protocol, set standards and launch the Pioneer Study led by ME.** **b) ME/FB to lead on an audit of the Pioneer Study and gather data when it is launched.** **c) ME to draft correspondence to Lung Pathway Board and MDT leads clarifying current position and future plans for the Resectable Stage III-N2 Protocol so that this is communicated comprehensively across all units.** **d) The definition of "Resectable" agreed by the surgical team is to be shared with all board members for MDTs to use as a reference.**

8. Pathway Performance	
Discussion summary	JS presented the lung cancer pathway performance data for Q4 which is based on patients coming through the GP pathway. It was noted that following recent changes to Cancer Manager guidance, patients upgraded from X-ray to CT are now classed as suspected cancer two week wait referrals from CT report so there will be a shift in numbers within data provided in the future **7 Day Pathway Performance:** Q4 data was presented for patients seen through diagnostics by day 7. The lung pathway sees patients quicker than other pathways with 73% being seen by day 7. This is due to rapid access to diagnostics. **62 Day Pathway Performance:** Q4 performance for lung is 72.2% against a target of 85%. The data does not account for upgraded patients. The highest performing trust was East Cheshire with 100% and 33% in Tameside. JS discussed possible reasons why patients have breached including problems with internal diagnostics across trusts. Patient transfers between trusts was highlighted as a challenge. JS confirmed that such patients are not reflected in the data presented – these fall under 'complex breaches'. Gateway-C was noted as a helpful resource in terms of appropriate suspected lung cancer referrals. The responsibility and accountability of cancer performance is now being transferred to GM Cancer. JS is collating information around challenges and blockages in relation to the lung pathway for the GM Director of Operations Group. ME requested that the Pathway Board have sight of this.
Actions and responsibility	**a) JS to collate information around challenges and blockages and share with the Pathway Board. Actions relating to these findings will be built into sub-committee work plans.** **b) JS to present consultant upgrade data at future Pathway Boards.**

9. EBUS Review	
Discussion summary	HAN introduced Paper 5, an offered an overview of the recent EBUS service review. HAN provided an overview of current EBUS provision across the region, specifically the sector model. It was noted that an agreement exists within GM for EBUS providers to share capacity and contribute to a central database across the sites.

	The data presented by HAN was discussed in detail and key findings were presented. The difficulties in collecting the data were described. Data collection took place through site visits to the five EBUS sites (January – April 2019). Data collection included an assessment of capacity, origin of referrals, activity (demand) and turnaround times for the two time periods of April 2017-March 2018 and April 2018-December 2018. Key findings from the review were highlighted to the Board. There were 3,402 EBUS slots per year across GM and eastern Cheshire and 1,678 EBUS procedures took place in 2017/18. Activity for the first nine months of financial year 2018/19 was highlighted. It was noted that the data submitted for Pennine needs revisiting as there are nuances in the service that need to be taken into account. The report shared with the Board is a preliminary document. Gaps in the data for some units were recognised and the question of whether the data fairly reflects EBUS was discussed by the Board. The Board were asked to reflect on EBUS itself and the recommendations for the future. It was highlighted that the data is encouraging as it shows room for capacity. It was suggested that going forward, the Board should focus on patients who live in deprived areas and need access to treatment. CH informed to the Board that the EBUS review was requested by the commissioners so as part of the next steps with this exercise, the paper will be shared with commissioners in June. CH invited board members to make contact with any requested amendments to the report by COP Friday 31st May.
Actions and responsibility	**a) CH/HAN/RA to follow-up Pennine's EBUS data with LB to address the queries raised.** **b) ALL to send comments on the EBUS review preliminary paper to CH by 31/05/2019.**

10. Prehab4Cancer update	
Discussion summary	ZM was invited to present an update on the Prehab4Cancer service. The Prehab service launched in April 2019 and in 3 weeks, the programme has received 60 referrals. Out of the 60 referrals, 12 lung referrals have been received across Wythenshawe (1), MRI (7) and Salford (4). The Prehab4Cancer website was briefly explained and the referral process was discussed. Currently, Prehab is in its early stages and so is focused on surgical patients. The aim is for the programme to be accessible for all patients in the future. ME encouraged the board to support the Prehab4Cancer service and refer all eligible patients when appropriate.
Actions and responsibility	**a) ZM to distribute Prehab packs for referrers for information.** **b) ZM to attend future Pathway Board meetings and provide a specific Prehab progress report for lung offering updates on referral numbers, outcomes and patient experience.**

AOB	
Discussion summary	ME thanked members of the board for their attendance. Members were reminded to attend the Lung Education Event on Monday 24th June and promote the event to their teams. Members were encouraged to promote the NLCFN conference with their teams, particularly releasing CNS's to attend: https://www.nlcfn.org.uk/annual-conference
Actions and responsibility	NA.

Future Meeting Dates:

- Monday 23rd September 2019, 15:00-17:00, Manchester Airport Marriott Hotel, Hale Road, Hale Barns, Manchester, WA15 8XW
- Friday 20th December 2019, 11:00-13:00, Manchester Airport Marriott Hotel, Hale Road, Hale Barns, Manchester, WA15 8XW
- Monday 23rd March 2020, 15:00-17:00, Manchester Airport Marriott Hotel, Hale Road, Hale Barns, Manchester, WA15 8XW