

## Greater Manchester Cancer Board Agenda

**Meeting time and date: Monday 28<sup>th</sup> March 2022, 2:15pm-5pm.**

**Venue: MS Team Virtual Meeting**

**Chairs: Roger Spencer / Andrea Green**

#	Item		To	Lead	Time
1	Welcome and apologies Minutes from the previous meeting, 20 <sup>th</sup> September. Action log and matters arising - ICS	Verbal Paper 1, Pg. 2  Paper 1, Pg. 13	- Approve Update	Roger Spencer	10'
2	Overview of GM Health System and Covid Recovery - Planning update 2022/23 - Cancer 10 Year Plan - GM Cancer Annual Report	Verbal  Presentation 1  Paper to follow	Update	Dave Shackley Claire O'Rourke Tom Thornber	20'
3	Cancer Recovery & Performance	Presentation 2	Update	Lisa Galligan Dawson	20'
5	GM Cancer Trials: Improving recruitment	Paper 2, Pg. 16 Presentation 3	Update	Dave Shackley & David Thomson	10'
4	Evaluation of Single Queue Diagnostic Pilot and case for change	Paper 3, Pg. 21 Presentation 4	Update	Matthew Evison & Lisa Galligan-Dawson	15'
6	GM Cancer Key Outcome Metrics	Paper 4, Pg. 37	Update	Alison Jones	10'
<b>15 Minute Break</b>					
7	Inequalities Board Update	Paper 5, Pg. 53		Alison Jones	15'
8	Breast Pathway Improvement	Paper 6, Pg. 67 Presentation 5		Clare Garnsey & Claire Goldrick	20'
9	Lung Pathway Improvement	Paper 7, Pg. 94 Presentation 6		Matthew Evison & Lisa Galligan-Dawson	20'
11	Papers for Information: <ul style="list-style-type: none"> <li>▪ Pathway Board Update</li> <li>▪ Lynch Syndrome Testing &amp; Compliance in Greater Manchester</li> <li>▪ Workforce and Education Update</li> </ul>	Paper 8, Pg. 141  Paper 9, Pg. 144  Paper 10, Pg.149	Update  Update  Update	Alison Armstrong  Michelle Leach  Suzanne Lilley	-
12	AOB	Verbal	Discuss	All	10'

**The next meeting is scheduled Monday 23<sup>rd</sup> April 2022, 3pm-5pm**

## Greater Manchester Cancer Board Minutes and Actions

**Meeting time and date: Monday 28th March 2022, 14:15pm-17:00pm**  
**Venue: Virtually, via MS Teams**

<b>Members present</b>			
<b>Name</b>	<b>Role</b>	<b>Organisation/Representation</b>	<b>Attendance 2020/2021</b>
Roger Spencer (RS)	Co-Chair / Chief Executive	The Christie Foundation NHS Trust	6/6
Andrea Green (AG)	Co-Chair	Stockport CCG	6/6
Dave Shackley (DS)	Director & Clinical Lead	GM Cancer	6/6
Claire O'Rourke (COR)	Managing Director	GM Cancer	5/6
Susi Penney (SP)	Associate Medical Director	GM Cancer	6/6
Sarah Taylor (ST)	GP Lead	GM Cancer	6/6
Lisa Galligan-Dawson (LGD)	Performance Director	GM Cancer	5/6
Suzanne Lilley (SL)	Cancer Workforce Lead	GM Cancer	5/6
Alison Jones (AJ)	Interim Director of Commissioning - Cancer Services	GM Joint Commissioning Team   GM Cancer	6/6
Cathy Heaven (CMH)	Programme Director of Cancer Education	The Christie NHS Foundation Trust	6/6
Alison Armstrong (AA)	Programme Lead	GM Cancer	6/6
Anna Perkins (AP)	Communications and	GM Cancer	3/6
Rhidian Bramley (RB)	Engagement Lead	GM Cancer	5/6
Nabila Farooq (NF)	User Involvement Rep PaBC	Macmillan User Involvement Programme	5/6
Ian Clayton (IC)	User Involvement Rep PaBC	Macmillan User Involvement Programme	2/6
Fiona Noden (FN)	Chief Executive Officer	Bolton Foundation NHS Trust	0/6
Leah Robins (LR)	Rep for GM Chief Operating Officers	Northern Care Alliance Group	5/6
Andy Ennis (AE)	Deputy Chief Executive/Chief Operating Officer	Bolton Foundation NHS Trust	2/6

Rob Bellingham (RobB)	Managing Director	GM Joint Commissioning Team	6/6
Professor Janelle Yorke (JY)	Executive Chief Nurse & Director of Quality	The Christie NHS Foundation Trust	5/6
Katherine Butler (KB)	Cheshire CCG Clinical Lead for Cancer and End of Life	Cheshire CCG	1/6
Sarah Price (SP)	Chief Officer	GM Health & Social Care Partnership	3/6

In attendance		
Name	Role	Organisation/Representation
Sadhbh Oliver (SO)	Senior Team Administrator	GM Cancer
Beth Sharratt (BS)	Project Manager (Health and Social Care VCSE Engagement)	GMCVO
Chris Harrison (CH)	Executive Medical Director	The Christie NHS Foundation Trust
Claire Trinder (CT)	Director of Research Strategy and Operations	Manchester Cancer Research Centre
Clare Garnsey (CG)	Breast Clinical Pathway Lead	Bolton Foundation Trust
David Thomson (DT)	Head and Neck Clinical Pathway Lead	The Christie NHS Foundation Trust
Jane Pilkington (JP)	Deputy Director Population Health	GMHSCP
Jonny Hirst (J.Hirst)	Answer Cancer Programme Manager	Answer Cancer
Lisa Spencer (LS)	Associate Director of Strategy	Northern Care Alliance NHS Group
Matthew Evison (ME)	Lunch Clinical Pathway Lead	Manchester University Foundation Trust
Teresa Karran (TK)	Regional NHS Relationship Manager	CRUK
Tim Humphreys (TH)	Strategic Partnership Manager	Macmillan Cancer Support

<b>GM Cancer Team members</b>	Alison Foxley	GM Cancer
	Chris Repperday	GM Cancer
	Claire Goldrick	GM Cancer
	David Holderness	GM Cancer
	Jane Cronin	GM Cancer
	Jaquie Lavelle	GM Cancer
	Jenna Lane	GM Cancer
	Jess Carroll	GM Cancer
	Jess Docksey	GM Cancer
	Joseph Henshaw	GM Cancer
	Libby Mills	GM Cancer
	Louise Lawrence	GM Cancer
	Michelle Fairhurst	GM Cancer
	Molly Pipping	GM Cancer
	Philip Graham	GM Cancer
	Rebecca Davies	GM Cancer
	Sarah Lyon	GM Cancer
	Sue Sykes	GM Cancer
	Susan Todd	GM Cancer
	Stella Ruddick	GM Cancer
	Tara Schaffe	GM Cancer
	Rebecca Davies	GM Cancer

<b>Apologies</b>			
<b>Name</b>	<b>Role</b>	<b>Organisation</b>	<b>Attendance 2020/21</b>
Suzanne Lilley (SL)	Cancer Workforce Lead	GM Cancer	5/6
Anna Perkins (AP)	Communications and	GM Cancer	3/6

<b>1. Welcome and Apologies, Minutes of the last meeting &amp; Action log and matters arising</b>	
<b>Discussion summary</b>	<p>RS welcomed all to the meeting, apologies were noted, and the minutes of the previous meeting held on 20<sup>th</sup> September 2021 were approved as an accurate record.</p> <p>RS highlighted that the agenda had been extended to cover the long-term activities that had been undertaken from a Greater Manchester Cancer (GMC) perspective.</p> <p>RS thanked AG for the work and support they had provided to GMC and the board, as they will be due to retire at the end of April. RS highlighted that Anita Rolfe will be taking over AG's role within cancer board and with GMC</p>
<b>Actions and responsibility</b>	No action required.

<b>2. Overview of GM Health System and Covid Recovery</b>	
<b>Discussion summary</b>	<p>DS provided information around both the current circumstances in Greater Manchester (GM) relating to covid and that over the omicron wave.</p> <p>It was recognised that there is currently a large national community infection rate, however these community-based cases were not being transferred into critical patients. Within GM 10-12% of the patients in hospital beds were covid positive, however DS highlighted that they were predominantly in hospital for another reason and not covid. Furthermore 15% of hospital beds in GM were currently filled with patients who were fit for discharge but were unable to be sent home, due to constraints that had been put on the system as a result of Covid.</p> <p>Finally, DS referenced a piece of analysis that had been undertaken and published in the health service journal. This publication outlined the deterioration of elective services that had occurred as a result of covid. It was recognised that whilst electives would begin to increase, it would be an extended period of time until they could return to pre-covid capacity.</p> <p><b><u>The GM Cancer delivery plan for 2022-23</u></b></p> <p>AJ presented on the GM Cancer delivery plan for 2022-23. AJ noted that the initial plan had been submitted Thursday 24th March 2022. It was recognised that the planning pack provided a greater degree of steer this year providing indicative funding allocations against 4 areas.</p> <p>AJ provided a summary of the initial funding allocations that had been provided in the plan which can be found in the GM Cancer Delivery Plan presentation. There is an expectation that those areas which the alliance do not yet know the funding allocation for, such as NHS Cancer Screening and Primary Care Pathways, will come in Q3.</p> <p>Following the submission, AJ outlined that GM Cancer are now awaiting feedback and any possible changes that may be required. Furthermore, within the submission a number of risks were identified by GMC to the National Cancer Programme which can be found in the GM Cancer Delivery Plan presentation.</p> <p><b><u>ICS &amp; ICB</u></b></p>

	<p>TT outlined that the GM Cancer system is now operating in the context of a long-term plan and is in a transitional process into an integrated care system that will commence on the 1<sup>st</sup> July. Furthermore, GM will be anticipating a new medical and finance director for the ICB.</p> <p>TT outlined three ways in which cancer services will operate under the ICB.</p> <ol style="list-style-type: none"> <li>1. There will be a whole system approach to cancer as part of a GM system.</li> <li>2. The GMC will be the coordinating function across the GM health system on behalf of the ICB for Cancer</li> <li>3. GMC will be deploying a pathway-based approach that will allow GM to develop innovation and operate across the 10 GM localities</li> </ol> <p>TT also noted the three key aspects of the cancer operating models.</p> <ol style="list-style-type: none"> <li>1. Trying to achieve an improvement and continuation of improved sustainable recovery.</li> <li>2. A focus on inequalities and engaging localities to understand their challenges and how these will be addressed in the context of the revised cancer operating model.</li> <li>3. Instil a model that allows innovation to take place in GM.</li> </ol> <p>TT updated that the GMC will be going out to appoint a director of cancer early diagnosis and strategic planning on a permanent basis. This post is currently held on an interim basis by Alison Jones and will be recruited into the Alliance on a permanent basis.</p> <p>TT summarised that the next key step for GMC would be to show how the pathway boards and cancer alliance can relate to: the cancer providers across the system, the screening functions in GM and primary care in localities. As a result, a workshop has been developed around how these interdependencies and communication lines will be built across GM.</p> <p><b><u>Ten Year Plan</u></b></p> <p>DS provided context around the Ten Year Cancer Plan which will focus around the proposal of new innovations within GM. DS noted that the GMC had coordinated a list of innovation proposals, which had been pulled together through a round table discussion with several GM system leads and through written submissions from around the system.</p> <p>A briefing paper outlining how GM can be placed within the national programme in relation to innovation had been reported to PFB. It was recognised that a significant number of the suggestions that had been submitted from the system were focused on: screening, early-stage diagnosis, faster diagnosis and working closely with primary care networks.</p>
<p><b>Actions and responsibility</b></p>	<ul style="list-style-type: none"> <li>• DS to share summary paper that was sent to PFB alongside other documentation relating to the Ten-Year Plan with member of the board.</li> <li>• A work force update is to be added to the next Cancer Board agenda.</li> </ul>

<b>3. Cancer Recovery &amp; Performance</b>	
<p><b>Discussion summary</b></p>	<p>LGD provided information around the current cancer performance rates within GM based off the GM weekly tracked metrics. Please refer to the GM Cancer Board Cancer Recovery &amp; Performance slides for specific performance figures.</p>

	<ul style="list-style-type: none"> <li>• It was recognised that GM had significantly recovered its position in terms of referrals.</li> <li>• The PTL size in GM had also increased going from 8500 to 18,000</li> <li>• LGD noted that there were still issues with the number referrals reaching over 62 days</li> <li>• It was also recognised that the number of patients coming from a 2 week wait or GP referral source had become significantly better since the pandemic.</li> </ul> <p>LGD considered the most concerning performance figures to be those relating to Faster Diagnosis which stood at 54%. Due to the concern around these figures, it was recognised that efforts in GM would be focused on the front end of the cancer pathways, as this is how performance would be recovered overall in GM.</p> <p>LGD additionally outlined some potential changes that were being made to the Cancer Waiting Times Guidance, Version 12. Please refer to slide 5 on the GM Cancer Board Cancer Recovery &amp; Performance presentation for the 8 key changes that were highlighted.</p> <p>In relation to approaching recovery in GM it was summarised that time will be spent looking at data to understand disaggregated pathways. There will then be a focus on looking at best practice, with the intention that a guide will be created to support organisations and take the best out of GMs learning. A cancer management resource review will be undertaken, and a GM recovery board will be arranged, which will set up a forum to track and monitor the systems improvement and ensure that all actions that are being undertake support both recovery and sustainability. It will also be ensured that the alliance will work alongside the various provider organisations in the GM system in relation to both planning and work forums.</p> <p><u>Questions</u></p> <p>RS noted that the Cancer Waiting Time standard change would see the removal of the first metric to the first time a patient is seen in hospital i.e. the 2 week wait standard. Instead, there will be a new additional target around when patients receive a diagnosis. RS further commended the amount of work and coordination that had been put in by the GMC team to get this system approach and overview.</p> <p>RS further thanked colleagues from across the system for the work that had been done despite the challenges that there has been in the system. RS queried what the current situation was with waiting lists in GM for cancer patients.</p> <p>LGD detailed that patients are being monitored and are receiving treatment within 28 days from a P2 perspective, however the target in the waiting times is 31 days, which GM is close to reaching and will likely be on track to reach from quarter 1.</p> <p>It was recognised that there are some patients who have waited longer in the system but this has been primarily due to patient-initiated delays, such as people not wanting to come forward due to covid. In these circumstances patients have been fully informed of the risks, have had clinical conversation and have been deemed to have the capacity to not come forward at that time.</p>
<p><b>Actions and responsibility</b></p>	<ul style="list-style-type: none"> <li>• LGD to share the CWT documents out to the board with the appropriate feedback mechanism.</li> </ul>

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**4. GM Cancer Trials: Improving recruitment**

<b>Discussion summary</b>	<p>DT introduced the work that is being undertaken around the improvement of access and inclusivity for patients into research studies in GM.</p> <p>It was outlined that the MCRC is attempting to co-create research around the current inequalities within cancer patients and increase recruitment to cancer research. As a result, the GMC alongside other organisations have put together a working group to create 12 key principals which are intended for reflection and use in clinical pathway groups to increase recruitment to research studies, reduce research inequalities and support the broader connections between clinical and research groups in GM. Please see the 'Greater Manchester Cancer Research Principles for Professionals' paper for the 12 specific principals and the work that was undertaken around them.</p> <p>Following the creation of the principals, the working group aims to further distribute the principals for feedback and baseline readily available data around what research is currently being offered and who is up taking the research that is available.</p> <p><u>Questions</u></p> <p>It was recognised that there is currently a lack of data to show inequalities in research, and whilst people suspect this is likely a problem in the system, baseline data is required to further understand this.</p> <p>Lisa Spencer queried how this work will link into MDT forums and referenced one of the 12 principals that were included in the paper that links to MDTs. DT outlined that MDTs will be a key focus for this work as they provide an opportunity for early recognition of trials for patients and are a point in which trials could be matched to patients. It was also recognised that through suggesting trials earlier alongside early advocacy from clinicians, there would likely be an increased chance that patients would be willing to enrol in research studies.</p>
<b>Actions and responsibility</b>	<ul style="list-style-type: none"> <li>The use of MDTs to propose cancer clinical trials is to be brought back to a future Cancer Board agenda.</li> </ul>

**5. Evaluation of Single Queue Diagnostic Pilot and case for change**

<b>Discussion summary</b>	<p>LGD emphasised that specialist diagnostics have been a key area which have seen large inequity for cancer patients across GM. Therefore, the Single Queue Diagnostic pilot came about following a recognition of this inequity and looked for a means to reduce this variation.</p> <p>Matthew Evison (ME) provided an update and summary of the work detailed in the 'Single Queue Diagnostics – Pilot Evaluation' paper included in the cancer board paper pack.</p> <p>Following the Single Queue Diagnostics pilot with EBUS testing, it was found that there was reduction in waiting time by 21% over all hospitals, a reduction in variation by 42% and there was positive patient feedback.</p>
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	<p>ME outlined the future vision for this programme of work. It is hoped that this Single Queue Diagnostic Framework can be applied to a broader range of specialist cancer diagnostics both in lung and other specialties. ME proposed that the pilot now provides a proof of concept of a functional platform that can allow GM to manage its capacity and demand, which could be used in a GM cancer diagnostic system for other specialist testing which could create transformational change.</p> <p><u>Questions</u></p> <p>RS highlighted that there had been broader interest in this project from the national team.</p> <p>LR expressed that from a COOs perspective, some form of single queue reporting would need to be created.</p> <p>LGD highlighted that those organisations who had used Infoplex had not seen their wait time go above 4 days thus demonstrating that a single queue would drive the improvement in wait times across GM; through both the loss of time spent on the booking process and through the synchronization of booking.</p> <p>Roger Prudham queried whether there had been any difficulties coordinating the information back from the providers into MDTs. ME recognised that the current pilots were purely based around scheduling from existing reporting mechanisms, however ME highlighted that this work if advanced could involve a system in which results were immediately received back to the team. Roger Prudham advised that this could be linked with other work that is being done in GM around the integration of data.</p>
<p><b>Actions and responsibility</b></p>	<p>No action required.</p>

**6. GM Cancer Key Outcome Metrics**

<p><b>Discussion summary</b></p>	<p>AJ provided an update on the GM Cancer Key Outcome Metrics paper that was shared with the board. It was highlighted that the data and the messages that are included in the paper are conversations that are hoped to be moved forward with the 10 localities in GM, following support from cancer board.</p> <p>The paper outlined the position from a GM perspective in relation to survival and staging early diagnosis cancer.</p> <p>It was recognised that whilst there had been an improvement in figures, there had also been locality variation by either pathway or location. It was asked that with the support of the pathways and cancer board, if these figures could be taken into some of the localities for detailed discussions around the cause of certain variation, rather than being discussed at a GM level. This was recommended as the people in the specific areas would know the areas and populations better and will likely already be doing large amounts of work for these areas.</p> <p>RS noted that this was integral part of how GMC will operationalise the planning activity in specific areas.</p>
<p><b>Actions and responsibility</b></p>	<p>No action required.</p>

<b>7. Inequalities Board Update</b>	
<b>Discussion summary</b>	<p>AJ provided an update to the board on the Health Inequalities Strategy and Implementation Plan presented in 2021.</p> <p>AJ detailed some of the work that had been undertaken by the GMC around inequalities. This work included:</p> <ul style="list-style-type: none"> <li>• The work that had been done against a range of actions in relation to inequalities as was detailed in the board paper. This included work with: the user involvement programme, the voluntary and community sector, prevention, research, primary care networks and more.</li> <li>• Each pathway board within GM Cancer had been asked to identify a project relating to inequalities. The inequalities board will then work with the pathways to implement the proposed projects.</li> <li>• The inequalities board was linking in with GMs 10 localities on cancer specific inequalities pieces for their PCNs.</li> </ul> <p>AG provided support for the work that had been undertaken for by the inequalities board and queried whether there would be a time scale of when the recommendations around the actions could be fed back to the Cancer Board. AJ agreed that they would be happy to bring back an updated plan to the next board.</p>
<b>Actions and responsibility</b>	<ul style="list-style-type: none"> <li>• AJ to provide a broader communication of the activities being undertaken through inequalities board with further information on how non-board members can be engaged with the inequalities work.</li> </ul>

<b>8. Breast Pathway Improvement</b>	
<b>Discussion summary</b>	<p>Clare Garnsey (CG) updated the board on the work that was being done to stabilise Greater Manchester breast services and improve performance against national cancer waiting time standards. This work was summarised in the paper that was presented in PFB and is included in the cancer board paper deck.</p> <p>Within the work around breast services in GM, CG highlighted several key areas that were being focused upon, including: Regional referral management, the mastalgia pathway and radiology workforce expansion.</p> <p>Surrounding the work that undertaken so far, CG referenced the workshops that had been undertaken for this work in December. A proposal was then created in January which was approved by executive medical directors, COOs and the PFB in February.</p> <p>Going forward this work will aim to:</p> <ul style="list-style-type: none"> <li>- Analyse the feedback that had been received from the public facing and primary care breast education programme, which will be continued as ongoing programmes.</li> <li>- Submit a regional business case for this proposal based around the mastalgia pathway implementation workshops and radiology workforce accelerated training programme implementation meetings that have taken place.</li> </ul>

	<ul style="list-style-type: none"> <li>- Recruit to specialist nursing as well as GPER roles to deliver mastalgia telephone clinic, and recruit to regionally funded radiology training programmes.</li> <li>- Lastly, it will aim to audit breast cancer incidence in the over 40-year-old mastalgia population, to identify if mammographic investigation is justified in this group.</li> </ul> <p><u>Questions</u></p> <p>The work that had been undertaken around breast pathway improvement was commended by those in the board. DS further thanked CG for the work undertaken, particularly around the large amounts of progress that had been able to be made in just a few months. DS further noted how this relates to the significance of pathway boards and the work that can be achieved through them.</p> <p>TT also noted how the work around breast demonstrates what can be coordinated through a pathway board. It was further queried whether CG saw this as a rolling programme of other developments that would improve the pathway in other areas. CG noted that there was uncertainty as to how much should be done regionally vs how much should be provider led. It was recognised that this work will likely serve as a test bed for how quickly work can be taken through the system. CG further noted that if this work was a success there would be an aim to roll it out further along the pathway.</p>
<b>Actions and responsibility</b>	No action required.

**9. Lung Pathway Improvement**

<b>Discussion summary</b>	<p>Matthew Evison (ME) updated the board on the work that was being done in Greater Manchester around a Lung cancer performance review. ME referenced the 'Lung Cancer Performance Review' paper that summarised the work, which was included in the cancer board paper deck.</p> <p>ME provided context around the severity of lung cancer, referencing the national lung cancer audit and GIRFT report. Included in the GIRFT report were several recommendations which are hoped to be met in GM. ME noted that the GM tableau data system has been created to look at live data which looks at more up to date outcomes and has been set up to align with the GIRFT aspirational recommendations, to help identify where further work is required.</p> <p>ME provided an overview of the key strategic areas of work that the pathway would like to move forward with. These included:</p> <ul style="list-style-type: none"> <li>- A specialist diagnostic system which has been piloted through Single Queue.</li> <li>- The upscaling and roll out of a GM lung health check service.</li> <li>- Work with prehab4cancer to help increase systemic therapy rates, increase adjuvant therapy rates, and ensure the programme is accessible to patients with advanced stage disease.</li> <li>- Completing work around small cell, involving the utilisation of one of the EBUS services that have rapid on-site evaluation, which could be implemented across the region using Infoflex.</li> <li>- The last area being work around central tumour and the implementation of a extremely urgent pathway.</li> </ul>
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	<p>The work detailed in the paper is hoped to be carried forward through a small lung improvement group that can meet more frequently than a pathway board is able to.</p> <p>Questions</p> <ul style="list-style-type: none"> <li>▪ AJ requested a separate conversation with ME to link in around the work that is being undertaken in the early diagnosis steering group.</li> <li>▪ TT noted that this was prime example of how the pathway boards can have a total system impact.</li> <li>▪ ST emphasised the need for there to be a focus on the front end of pathways and the recognition in primary care with the expanding number of roles.</li> <li>▪ DS commended the work that been undertaken by ME and outlined that the work from both ME and CG provides examples of where GMs pathway board and related clinical groups can aim to take GM to the next level in its cancer care services. DS further detailed the possibility of ME leading an operational group that could work with the relevant lung cancer commissioners in each provider.</li> <li>▪ DS also suggested the creation of an Eform or virtual forum that clinical leads could put out to all front-line staff, so they could see what work is going on in each pathway. It was similarly noted that the GM Cancer website is soon to be launched and will be an area which people can go to get more detailed information regarding the alliance and its pathways.</li> </ul> <p>LGD put forward the immediate asks of the paper and asked the board for their support to roll out some of some of the key actions to take forward to PFB. RS noted that the board were in support of taking forward these actions.</p>
<p><b>Actions and responsibility</b></p>	<p>No action required.</p>

<b>10. AOB</b>	
<p><b>Discussion summary</b></p>	<p>It was recognised that whether the next meeting would go ahead depended on how the covid situation in Greater Manchester escalated/de-escalated over the coming month.</p> <p>It was detailed that the GM Cancer Draft Annual Report is currently being finalised and will be circulate alongside the minutes from the board meeting.</p> <p>COR thanked AG for all the work they had done alongside the board and GM Cancer, including the work that had been done prehab for cancer which recently won a HSJ award.</p> <p>SS was also thanked for all the work they had done around the RDC programme of work which was running a year ahead of schedule and had recently saw 4 new sites go live with their Non-Site Specific pathways.</p>
<p><b>Actions and responsibility</b></p>	<p>SO to circulate the GM Cancer Draft Annual Report alongside the minutes from the March GM Cancer Board minutes.</p>

**The next meeting is scheduled on Monday 23<sup>rd</sup> May 15:00-17:00pm**

## Action Log

### Prepared for the 23<sup>rd</sup> May GM Cancer Board

Log No.	AGREED ON	ACTION	STATUS
c/f 12.21	19 <sup>th</sup> July 2021	Paper 2b VCW User Involvement summary to be presented at the September Cancer Board	<b>Action closed</b> GM Cancer agenda item no longer required. Paper for information submitted.
c/f 14.21	20 <sup>th</sup> September 2021	Minutes of the last meeting, 19th July 2021, to be uploaded to the GM Cancer webpage	<b>Action closed</b>
c/f/ 15.21	20 <sup>th</sup> September 2021	A paper / update will be provided at a future board meeting on: <ul style="list-style-type: none"> <li>▪ Pathway Boards + GM Cancer</li> <li>▪ Trials for Pathway Boards</li> <li>▪ Education</li> <li>▪ GM cancer survival rate – data</li> </ul>	<ul style="list-style-type: none"> <li>▪ Pathway Boards + GM Cancer- Update to be provided</li> <li>▪ Trials for Pathway Boards- Update to be provided</li> <li>▪ The survival data is to be included in the GM Cancer Key Outcome Metrics paper.</li> </ul> <b>Action closed</b> <ul style="list-style-type: none"> <li>- All papers listed above have now been shared with the GM Cancer Board membership.</li> </ul>
c/f 16.21	20 <sup>th</sup> September 2021	RDC patient experience to be presented at a future board meeting	<b>Action closed</b> GM Cancer agenda item not required. Sue Sykes (RDC Programme Lead) to continue to ensure that qualitative evidence is included in any review of the RDC model in GM.
c/f 17.21	20 <sup>th</sup> September 2021	An inequalities action plan with timelines is to be produced and shared at the January 2022 Cancer Board meeting	January Board scaled down, inequalities update to be provided. Update: <b>Action closed.</b> AJ provided a inequalities update alongside a paper at the March board.
c/f 18.21	20 <sup>th</sup> September 2021	Suzanne Lilley (SL) to link in with the User Involvement team in relation to them joining the volunteers programme	<b>Action Closed.</b> An initial scoping exercise has been conducted to understand how cancer volunteers are currently being recruited, trained and utilised across all GM trusts. The workforce and education team will continue to work with volunteer teams  and the cancer workforce to define next steps and explore ways to increase recruitment, increase EDI, and standardise training / support. The

			scoping has been discussed with the GM Cancer UI team and once next steps have been defined, there will be focused engagement with the UI community.
19.21	January 2022	Cancer Alliance to circulate briefing note in February 2022.	<b>Action closed</b> A briefing was circulated on the 2 <sup>nd</sup> March 2022 to the GM Cancer Board membership.
20.21	January 2022	SO to add the GM Alliance focus on the national planning guidance to the agenda for the next meeting.	<b>Action closed</b> AJ provided an update on GM Cancers approach to the national planning guidance.
21.21	January 2022	DS to provide an update of the Social Care plan and Taking Charge plan and their further progression, at the next meeting.	<b>Update</b> Added to the May agenda to be discussed.
22.21	January 2022	LGD to present the evaluation and case for change for the Single Queue Diagnostic programme at the next meeting.	<b>Action closed.</b> LGD and ME presented on both items during the March Board, as well as circulating supporting papers on both items.
23.21	January 2022	LGD to provide an update on lung clinic at the next meeting.	<b>Action Closed.</b> LGD and ME provided a update on the Lung clinic in the March Board under their presentation on Lung pathway improvement
24.21	January 2022	SO to extend the time of the March Cancer Board unless there are any severe changes in the system.	<b>Action closed.</b> Board Extended.
25.21	March 2022	DS to share summary paper that was sent to PFB alongside other documentation relating to the Ten-Year Plan with members of the board.	
26.21	March 2022	SO to add a workforce update to the next Cancer Board agenda.	<b>Update</b> Added to the May agenda.
27.21	March 2022	LGD to share the CWT documents out to the board with the appropriate feedback mechanism.	<b>Action Closed</b>
28.21	March 2022	The use of MDTs to propose cancer clinical trials is to be brought	

		back to a future Cancer Board agenda.	
29.21	March 2022	AJ to provide a broader communication of the activities being undertaken through inequalities board with further information on how non-board members can be engaged with the inequalities work.	
30.21	March 2022	SO to circulate the GM Cancer Draft Annual Report alongside the minutes from the March Board minutes.	<b>Update</b> Awaiting finalised version of the GM Cancer Annual Report.

<b>Title of paper:</b>	Greater Manchester Cancer Research Principles for Professionals 'A Framework for Disease-Specific Clinicians' November 2021
<b>Purpose of the paper:</b>	To increase GM Cancer research patient involvement and equity of access
<b>Summary outline of main points / highlights / issues</b>	<ul style="list-style-type: none"> <li>• For the GM CRN in 2020/2021, 25.5 people per 1000 (2.5%) population participated in research trials</li> <li>• GM is the top recruiter to NIHR cancer trials in the UK by size of population but scope for improvement to increase patient access to: NIHR clinical trials, experimental cancer research, biobank sampling</li> <li>• Anecdotal evidence of inequalities in cancer research recruitment by GM Cancer provider, disease groups and under-served populations.</li> <li>• Inequities must be addressed to guarantee fairness for the individual, to improve treatment outcomes within the system, and ensure generalisability of research effect/feasibility of intervention.</li> <li>• A group was formed to baseline these data (to start with The Christie), make recommendations to the Cancer Board, and for actions disseminated via PWBs to increase research activity/equity.</li> </ul>
<b>Consulted</b>	<p>David Shackley – Co-Chair</p> <p>David Thomson – Co-Chair</p> <p>Sarah Doherty-Fallon</p> <p>Alastair Leslie-Dakers / Sequoia Chapman</p> <p>Robert Bristow</p> <p>Nigel Bundred</p> <p>Alison Armstrong</p> <p>Claire Goldrick</p> <p>The Head &amp; Neck Pathway Board</p>
<b>Author of paper and contact details</b>	<p><b>Name: Dave Shackley, David Thomson</b></p> <p><b>Title: DS-Director of Greater Manchester Cancer, Clinical Lead for Cancer Domain MAHSC</b></p> <p><b>Email: <a href="mailto:David.Shackley@nca.nhs.uk">David.Shackley@nca.nhs.uk</a></b></p>



# Greater Manchester Cancer Research Principles for Professionals

## 'A Framework for Disease-Specific Clinicians'

November 2021

### Executive Summary

Greater Manchester (GM) has an excellent record relating to cancer research, both developing new knowledge and treatments, and in recruitment. However, we can always do better. There still exists pockets of excellence across our pathways and some areas where there is much less research.

There are differences in access to trials and novel approaches between different sites, different pathways, and patient communities in GM, and there is, in places, little structured information available for patients to understand research opportunities that may be available, and no widespread use of digital technology approaches to help understanding and target recruitment.

This document provides a framework of principles to be considered by the different Greater Manchester Pathway Groups, to act as a focus to improve the research offer for all cancer patients in GM. The principles were agreed by a working group\* set up by GM Cancer in autumn 2021.

**It is expected that disease-specific pathways boards will discuss and consider this document and provide an annual report addressing progress against each of the principles.**

### Introduction

A Principle of the NHS Constitution for England is for the NHS to proactively conduct research to improve the current and future health and care of the population. **There is evidence for an association between the engagement of healthcare providers and staff in research, and improvements in healthcare performance**, for example, hospital care quality commission ratings and patient survival rates.

Within England we have the NIHR (National Institute for Health Research) CRN (Clinical research Network) which is unique as a national research infrastructure, and the body is charged with facilitating research recruitment across 30 specialities in 15 geographical areas. Greater Manchester, East Cheshire and East Lancashire constitute one such area (GM CRN) and it works with all the localities and hospitals to provide infrastructure and support trial recruitment.

The NHS pledges to inform the public/ patients of research studies in which they may be eligible to participate. We know from the NIHR CRN GM Participant in Research Experience Survey 2020/2021 that **nearly all patients who contribute to research recognise the value of doing so and 97% would consider taking part in research again.**

A total of over 80,000 participants across 581 studies were recruited to CRN Portfolio studies across the GM CRN in 2020/2021, with an equivalent of 25.5 people per 1000 **(2.5%) population being a part of healthcare research in our region**, this despite the backdrop of COVID-19.

The NHS also sets out to provide fair and equitable services for all, to reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care. It follows that **under-served populations should have equal access to research trials**, to guarantee fairness for the individual, to improve treatment outcomes within a healthcare system, and to ensure generalisability of the research effect and feasibility of the intervention

### Cancer Perspectives in GM

**Within Cancer in GM, the NIHR reports that the local CRN is the highest recruiter to cancer research trials in England, when accounting for population size.** Despite this success, the National Cancer Patient Experience Surveys have shown that **most cancer patients (including in GM) are not offered a research opportunity.**

Data from large research cancer trials show significant additional difficulties in recruitment in relation to deprived communities and among ethnic minorities and this is an area of ongoing focus for the NIHR CRN and other local stakeholders. It is particularly important to note that often these poorly served communities (in terms of trial access) often have the highest disease burden.

The Manchester Cancer Research Centre (MCRC) is responsible for driving a consistent and integrated strategy for cancer research and innovation in GM, working with all local hospitals and communities and linking with the NIHR CRN and the Greater Manchester Cancer Alliance infrastructure. **The MCRC has a strategy that involves co-creating research with patients alongside professionals and has a specific interest in both (1) developing research into inequalities in cancer patients, and (2) increasing recruitment numbers to cancer research in general from under-served populations.**

In autumn 2021, the key partners of Greater Manchester Cancer Alliance, The MCRC and the NIHR CRN GM came together as a working group (see *appendix*) to discuss cancer research recruitment. The main ambition was to create a framework for use by disease-specific clinical groups to help increase recruitment, reduce research inequalities and support broader connections of the clinical and research communities.

### Purpose of the Document

This document provides a framework of principles to be considered by the different Greater Manchester Pathway Groups, to act as a focus to improve the research offer for cancer patients in GM. It is expected that disease-specific pathways boards will discuss and consider this document and provide an annual report addressing progress against each of the principles.

## 12 Key Principles:

1. **Patient access and recruitment to research trials shall be a high priority for all stakeholders** involved in cancer care in GM.
2. **Proposed innovation work on cancer services should specifically take account of any impact on research** and take every opportunity to increase the research offer for all eligible patients (**Research Impact Assessment**).
3. **Differences in cancer trial recruitment by GM Cancer provider, disease group and under-served populations will be monitored and summarised as an annual update/report.** It is particularly important to reduce inequalities in cancer research. This report will be jointly brought together by GM Cancer Alliance, NIHR CRN GM and the MCRC, and summarise action(s) being taken. The report will be presented at the GM Cancer Board. The NIHR will also publish quarterly updates by Provider and by Pathway and will send summary positions to the research leads on pathway boards.
4. **Mechanisms should be in place to facilitate & empower cancer patients in knowing what research trials are available in their pathway, and if possible, specific trials for their clinical situation.** This could be provider or pathway-led though with either model there **should be pathway ownership across GM.** This could include the use of new posts such as 'research facilitators', the use of new digital tools\*, 'research champions', a very visible and engaged Research Lead at Pathway Board, and a clearer communication plan with signposting to suitable materials/ websites/ videos.
5. **All clinically facing professionals will be expected to be aware of research trial opportunities available for their patients, with access to up-to-date resources to support this.** This could be provider or pathway-led though with either model there **should be pathway ownership across GM.**
6. All professionals involved in cancer research should be **fully compliant with Good Clinical Practice (GCP) certification and the system should encourage appropriate individuals to undertake dedicated research** training, research-related qualifications and study.
7. The **MDT meetings should be configured to ensure research is considered for each and every patient discussed, with relevant notes made** to facilitate relevant research discussions when the patient is seen in the clinic.
8. Stakeholders should work to offer **increased research opportunities in all settings** including smaller trusts and community settings.
9. GM will set the highest ambition(s) for cancer research recruitment including **maintaining its position as the #1 NIHR CRN region in England** and retaining a core Cancer theme within the 'One Manchester' BRC (Biomedical Research Centre status), CRUK major centre status, continuing as a key founding member of the ACED collaborative and other significant cancer initiatives which all **promote 'GM initiated' research.**

10. GM Cancer **pathway groups will be expected to regularly link with pathway-specific GM researchers to create closer links** between clinical care and GM-originated research. Connections should be strengthened with an **annual research-focussed event** involving the wider clinically facing and researcher teams.
11. Wherever possible trials originating in GM should be registered with the NIHR.
12. All major national-endorsed and relevant international 'marquee' studies in cancer research should be offered to GM patients.

*\* Digital solutions can be used/ developed to monitor access and recruitment to research trials including: dashboards/ applications of available trials, matching of trials to patient eligibility criteria, screening logs, real-time data capture*

#### Appendix

*The working group met originally as a group on 29<sup>th</sup> September 2021 with additional work prior and subsequently, including the agreement and creation of this document*

#### Working Group representation

Shackley David - Chair  
Fiona Blackhall  
Lydia Briggs  
Robert Bristow  
Nigel Bundred  
Sarah Doherty-Fallon  
Donal Landers  
Zoe Merchant  
John Moore  
Thomas Satyadas  
Javed Sultan  
David Thomson

DS/ DT

V1

15/11/2021

## Single Queue Diagnostics – Pilot Evaluation

<b>Title of paper:</b>	Single Queue Diagnostics – Pilot Evaluation
<b>Purpose of the paper:</b>	To advise the GM Cancer Board of the output relating to the ‘Single Queue Diagnostics’ pilot undertaken May - October 2021, focussed on two areas of specialist cancer diagnostics (EBUS and EUS)
<b>Summary outline of main points / highlights / issues</b>	<ul style="list-style-type: none"> <li>• In total, the SQD EBUS service saved 350 days across the 219 patients</li> <li>• In total, the SQD EUS service saved 66 days across the 50 patients</li> <li>• The SQD EBUS service reduced waiting times for EBUS across the participating sites by 21% despite the limitations of the pilot</li> <li>• The SQD EBUS service reduced the variation* in waiting times across the participating services by 42%</li> <li>• The SQD EUS service reduced waiting times across the participating sites by 7%</li> <li>• The SQD EUS service reduced the variation* in waiting times across the participating services by 60%</li> <li>• The top priority for 75% of EBUS &amp; 88% of EUS patients surveyed in this pilot was to have the fastest possible EBUS / EUS regardless of travelling</li> <li>• 96% of EBUS &amp; 88% of EUS patients surveyed in this pilot were ‘Very Happy’ or ‘Happy’ with the care they received</li> <li>• Over half of patients completing the experience of care surveys are from the most deprived areas of GM</li> </ul> <p><small>*Variation is described as the difference between the shortest average/median time and the longest average/median time</small></p>
<b>Consulted</b>	Single Queue Diagnostics Steering Group
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## 1. Context

The NHS constitutional standards for Cancer Waiting Times (CWT) are intended as quality markers and to deliver cancer care in clinically appropriate timescales. There are 9 Aspects to the constitutional standards. However, 'achieving cancer performance' refers to the delivery of the 62-day referral to treatment standard, seen as the primary indicator. These standards have not been achieved nationally for 8 years (NHS England, 2021) and in GM since Q3 2017/18, with the waiting times for both the diagnostic and treatment elements beyond the expected standards. These waiting times have been exacerbated by the Covid-19 pandemic.

It is well documented that delays in diagnosing and treating cancer results in poor physical outcomes (Neal et al, 2015), as well as having a psychological impact on patients (Miles, 2018). This improvement initiative supports the longer-term recovery of cancer waiting times delivery and the ultimate aim to achieve the CWT standards, whilst contributing to the NHS's commitment to reduce 'inequality' of which waiting time access is one key factor.

The cancer waiting times standards are reported as an aggregate position by organisation, which overlooks key elements of pathway waits including variation and performance at tumour site level. Additionally, performance breaches and compliance are allocated to a maximum of two organisations, when often pathways include up to four providers; thus not reflecting the full pathway components. Recovery initiatives must be designed to focus on improving pathways, and key milestones which make up the dis-aggregated data.

Illuminating issues related to variation and individual pathways which are currently concealed focuses on genuine pathway improvement and quality. Using disaggregated data is intended to bring a new approach to improvement, embracing some of the system re-design opportunities generated as a result of the pandemic.

Demand for diagnostics is recognised as one of the key challenges in meeting the cancer waiting time standards, particularly as specialist cancer diagnostics are not delivered at every Trust, and patients requiring these tests are often referred between providers.

## 2. The Single Queue Improvement Initiative

62-day breach analysis identifies performance issues related to both local and specialist diagnostics. The single queue concept and pilot looks solely at specialist diagnostics – those not delivered within every organisation, and those (CT Guided Biopsy) where services differ by provider.

The pilot was designed to include EBUS, EUS, CT Guided Lung Biopsy and CPEX. The latter two were removed from the primary pilot whilst further pathway work was undertaken. Therefore the pilot focussed on two key diagnostics for the Lung and OG pathways; EBUS and EUS. The pilot used a custom-based platform; Inflex®, which was configured to the needs of the concept.

The premise for the initiative is to bring together the available capacity and demand from each GM Trust through an interface system and is designed to:

- Improve experience of care for patients in GM awaiting cancer diagnostics through improved access and variability in waiting times (and ensuring no negative impact in experience of care from additional travel burden)
- Improve patient choice and enable patients access to the earliest appropriate diagnostic test within Greater Manchester
- Reduce variation in waiting time access
- Empower the referring hospital team to retain operational oversight of the patient pathway and thereby assess the most appropriate date and location of a diagnostic test to progress the pathway at maximal efficiency (e.g. considering co-dependent tests and timing of MDT meetings).
- Provide resilience in services across Greater Manchester during times of workload surge, sickness, annual leave and other factors affecting service delivery e.g. covid-19 pandemic
- Fully utilise all available GM assets for maximal efficiency including cancellation slots

In Greater Manchester we aim to develop cancer services that put the patient at the heart of everything we do. Services with adequate capacity to deliver rapid access and provide exceptional experience of care. Our motto is:

***'In Greater Manchester, we wait for patients, patients do not wait for us'***

### 3. EBUS (Endobronchial Ultrasound)

EBUS is an endoscopic test used to sample lymph nodes in the centre of the chest. This is a pivotal test in the lung cancer pathway as it can provide a diagnosis of lung cancer that has spread to lymph nodes and also exclude spread to lymph nodes and confirm early-stage disease. EBUS, therefore, is used for both diagnostic and staging and is classified separately as a staging EBUS and a diagnostic EBUS depending on the clinical scenario:

- Diagnostic EBUS: the focus of the procedure is to obtain adequate tumour samples to guide systemic therapy in advanced stage disease.
- Staging EBUS: the focus of the procedure is to accurately define the presence or absence of lymph node metastases across all lymph node areas. This will define the optimal treatment and outcomes.

The 2019 NICE Guidance on the diagnosis and management of lung cancer recommends that a PET-CT scan is performed prior to a staging EBUS to provide the best 'road map' as to which lymph nodes need sampling in the EBUS procedure. The benefit of EBUS-TBNA in the lung cancer pathway was demonstrated in the Lung-BOOST trial (Navani 2015) in which adding EBUS-TBNA to lung cancer staging reduced the total diagnostic pathway from an average of 29 days to 14 days and improved the median overall survival of patients from 312 days to 503 days through better treatment selection.

In Greater Manchester, all EBUS services adhere to a commissioner-led service specification that includes regular data submission for performance monitoring. Over-time, attainment and improvements in important quality indicators has been demonstrated. However, this analysis has also identified a failure to meet the national standard of EBUS-TBNA within 7 days of referral (Punjabi 2021). A subsequent utilisation and capacity analysis identified some services running at 100% utilisation and others at 50% utilisation suggesting an opportunity to improve the efficiency and productivity in the GM EBUS system.

Furthermore, the lack of visibility over waiting times in the current system is a particular challenge for organisations referring on to another provider for a diagnostic test. Waiting times fluctuate naturally, but in this specialist area, several services are reliant on one of two

key personnel; therefore sickness or annual leave can have a significant impact in waiting times.

Within the current processes, providers referring to other Trusts do so using an electronic proforma which is completed and submitted via email. The receiving Trust then reviews this, contacting the referring Trust for any further or missing information if needed, and then the patient is booked an appointment (usually by telephone). The referring clinical team and cancer tracking team would request notification of the date and monitor for this being completed. They would then list the patient for the appropriate cancer MDT when they know the report will be available and all other tests are completed. In essence, from the point of referral, the responsibility for the pathway is passed to the receiving organisation to arrange the EBUS; however, accountability remains with the referring Trust from a Cancer waiting Times perspective.

EBUS is currently delivered at 5 sites across GM. Capacity at each site serves their own patient cohort, and for neighbouring Trusts where indicated.

EBUS Site	Patients served at the site
MFT – Manchester Royal Infirmary	MRI + Stockport +Tameside & Glossop
MFT – Wythenshawe	Wythenshawe + Mid Cheshire + East Cheshire
MFT – North Manchester	NMGH + Oldham, Bury & Rochdale patients
Bolton	Bolton only
Wigan	WWL + Bolton & Salford

SQD Phase 1 – May 2021

SQD Phase 2 – August 2021

Non-participatory

### 3.1 Pilot Sites

The original pilot encompassed three GM Trusts (4 sites); MFT – Manchester Royal Infirmary, MFT – Wythenshawe, Tameside & Glossop and Stockport. Additionally, Mid-Cheshire Trust was included. These sites were selected as it was evidenced that Tameside & Glossop and Stockport without their own EBUS had longer waiting times than other sites.

The pilot enabled patients at all participating hospitals to utilise EBUS capacity at Wythenshawe and Manchester Royal Infirmary. The pilot commenced late May 2021 (Termed SQD Phase 1). Following an initial period of the pilot, the service was offered to the

remaining sites across GM. Bolton participated, coming online in August 2021 (termed SQD Phase 2), but Wigan and North Manchester did not.

The pilot involved EBUS providers displaying their capacity and available EBUS slots, and referrers directly booking the EBUS via the Infoflex® system. The system is designed so that whilst a patient is in clinic, the referrer would be able to see all available capacity, and in conjunction with the patient select an appropriate slot. This is a major divergence from existing practice where the EBUS provider dictates the date and time of procedures without any input from the referring team. The lung cancer pathway is complex (patients suitable for curative intent treatment often require 5-6 investigations to define their optimal treatment) and the referring team must orchestrate these tests in the most efficient way and the ability to plan tests with the patient and discuss dates/options will support an efficient and patient-centred pathway.

The system was designed by clinical teams and Infoflex® allowed certain rules to be applied that would show the referring team the earliest possible EBUS dates under different scenarios. For example, if a patient is taking the anti-coagulant warfarin, this must be stopped for 5 days before an EBUS. Infoflex, in this scenario, would only display EBUS appointments 5 days after the date warfarin has been stopped. This is also true for PET-CT. A staging EBUS may require a PET-CT prior to the EBUS and the referring team can decide if this is mandatory prior to the EBUS, and Infoflex® will then only display EBUS appointments 24 hours after the date entered for the PET-CT.

### **3.2 EBUS Pilot Evaluation**

The evaluation of the EBUS SQD pilot was split into three parts that aligned with the order of importance of the aims of this project (patient first, cancer system second and individual hospital teams third).

The pilot ran from May 2021 and concluded in October 2021 with phase 1 running May 2021 to August 2021 and phase 2 from August 2021 to the completion date. Across the entire pilot, 219 EBUS procedures were performed through the single queue pilot system.

### 3.2.1. Experience of care

The cancer nurse specialists and patient navigators at the referring teams were asked to offer a patient experience survey to those undergoing EBUS at the pilot sites during the pilot periods. It was felt these clinicians, already supporting these patients through a complex

pathway, were best placed to approach patients about the survey. The data was collected in a mixed-methods approach by handing out questionnaires in clinic and telephone calls with patients. A total of 43 patients (20% of patients participating in the pilot) completed the survey and is summarised below:

Question	Outcome
How happy were you to travel to the hospital where your test was done? 5-point Likert Scale (Very happy to Very Unhappy)	96%: 'Very Happy' or 'Happy'
How did you attend your appointment for your EBUS test?	79%: own / family / friends transport.
In your own opinion, what is the most important thing about having an urgent test? <ul style="list-style-type: none"> <li>o Completing the test as fast as possible regardless of which hospital it happens at</li> <li>o Completing the test as close to home as possible, even if that means waiting a little longer</li> <li>o Something else</li> <li>o None of the above</li> <li>o I'm not sure</li> </ul>	76%: completing the test as fast as possible regardless of which hospital it happens at
Overall, how well organised was the process of completing test 5-point Likert Scale (Very Organised to Very Disorganised)	97%: 'Very Organised' or 'Organised'
Is there anything else you would like to say about your experience during this test project or anything about where you feel patients should have urgent tests in Greater Manchester?	<p><i>"Very happy to go anywhere to get EBUS done as soon as possible so I can have results and start treatment as soon as possible"</i></p> <p><i>'I was extremely impressed by the teamwork &amp; professionalism at Wythenshawe hospital. They acknowledged my fears, made me feel comfortable and it would be good if I needed another to go back to Wythenshawe'.</i></p> <p><i>"Brilliant experience. Don't mind travelling to Wythenshawe even if it's awkward to get to"</i></p>

The Experience of Care Survey collected postcode information and therefore the respondents could be matched to a deprivation score. We therefore conducted a deprivation analysis to ensure the responses received were fully representative of the wider Greater Manchester population.

The patient postcodes were matched against The English Index of Multiple Deprivation (IMD) decile. According to the Department of Government and Local Authorities IMD deciles are calculated by ranking the 32,844 small areas in England from most deprived to least deprived and then dividing this data into 10 equal groups. The results were as follows:

- 53% of individuals that provided feedback reside in an area that has an IMD decile score of 4 or less (considered most deprived area)
- 31% of individuals that provided feedback reside in an area that had an IMD decile score of 6 or more (considered least deprived areas)

These results suggest there should not be a bias of results due to selection of the least affluent members of the GM community which could impact the views on travel.

### 3.2.2 EBUS Waiting Times

Data was collated for all EBUS's completed in the four months prior to the pilot (January – April 21) in MFT – Manchester Royal Infirmary, MFT - Wythenshawe and at Bolton. Patients referred from Tameside & Glossop and Stockport were separated out to give baseline waiting times data for each organisation. It identified that waiting times fluctuated within sites, and that there was significant variation between providers. The table below summaries the average waiting times of the participant sites prior to the pilot and during the pilot (May – October 21)\* alongside the reduction when comparing the waiting times pre-pilot and during the pilot.

*\*Bolton from August 21. The waiting time for EBUS in Bolton increased significantly in May and June 21. However, this was identified as special cause variation and outside the expected upper control limits. Therefore, this data has been excluded, so as not to overestimate improvements.*

EBUS pre and pilot waiting times summary

	<b>4 month average pre-pilot (days)</b>	<b>4 month median pre-pilot (days)</b>	<b>Average during pilot (days)</b>	<b>Average reduction in waiting times*</b>	<b>Median during the pilot (days)</b>	<b>Median reduction in waiting times*</b>
Royal Bolton	10.34	10.15	7.34	3.00	7.00	3.15
Manchester Royal Infirmary	10.65	10.49	10.64	0.01	9.30	1.34
Wythenshawe Hospital	6.43	6.32	6.27	0.16	6.10	0.22
Tameside & Glossop	11.60	11.10	8.57	3.01	8.20	2.90
Stockport	11.72	11.20	10.51	1.21	10.10	1.10
<b>Overall Pilot Sites</b>	<b>9.14</b>	<b>9.00</b>	<b>7.84</b>	<b>1.30</b>	<b>7.20</b>	<b>1.80</b>
<b>Overall variation in waiting time</b>	<b>6.89</b>	<b>4.88</b>	<b>4.37</b>	<b>2.52</b>	<b>4.00</b>	<b>2.93</b>

It should also be noted that patients from Mid Cheshire attend for EBUS at Wythenshawe. During this pilot, patients were booked via the Infoflex system, but solely at this Trust. Waiting times reduced at Mid Cheshire, despite not accessing different or additional capacity. Like Wythenshawe, the improvements noted are based on improved booking and referral processes.

**Key outcomes:**

**A saving of 1.8 days (median wait) to complete an EBUS equating to a 21% improvement. (1.3 days average equating to 14% improvement)**

**Reduction in the variation of waiting times for EBUS in GM of 2.93 days (42% reduction based on median wait.)**

#### 4. EUS (Endoscopic Ultrasound)

EUS is an endoscopic test used to in the detection and staging of Oesophageal cancer. The 2014 NICE guidance recommends that a PET-CT scan is performed prior to an EUS.

As with EBUS, the lack of visibility over waiting times is particularly challenging. Similarly, referral to other sites is via a proforma which is submitted via email. Furthermore, as with EBUS, the responsibility for the pathway is passed to the receiving organisation to arrange the EUS, whilst the accountability remains with the referring Trust from a Cancer waiting Times perspective.

EUS is currently delivered at 4 sites across GM. Capacity at each site serves their own patient cohort, and for neighbouring Trusts where indicated.

EUS Site	Patients served at the site
MFT – Manchester Royal Infirmary	MRI + Stockport +Tameside & Glossop
MFT – Wythenshawe	Wythenshawe + Mid Cheshire + East Cheshire
Salford	Salford + Oldham + Bolton
Wigan	WWL

SQD Phase 1 – August 2021

Non-participatory

##### 4.1 Pilot Sites

The pilot encompassed the ‘Northwest’ Sector – Bolton, Wrightington, Wigan and Leigh and Salford Royal. EUS capacity for Bolton patients is routinely via Salford. The pilot allowed Salford to refer to Wigan, and vice versa, and for Bolton patients to access either of the EUS facilities. The pilot for EUS was delayed, but came online August 2021.

The EUS pilot operated in the same way as the EBUS pilot, allowing refers to visualise all available EUS capacity and choose, in conjunction with the patient. The Infoflex® system was configured in conjunction with the clinical teams for EUS as it was for EBUS.

## 4.2 Pilot Evaluation

The pilot ran from August 2021 and concluded in October 2021. Across the entire EUS pilot, 40 EUS procedures were performed through the single queue pilot system.

### 4.2.1 Experience of Care

The same questionnaire was used for the EUS patient cohort. A 20% response rate was received. Similar themes were identified, with 7 out of the 8 patients (88%) confirming access to the earliest appointment being the most important aspect, even if this means travelling further. 7 out of 8 (88%) also reported that the process was well organised.

### 4.2.2 EUS Waiting Times

Data was collated for all EUS's completed in the four months prior to the planned pilot (January – April 21). As with EBUS it identified that waiting times fluctuated within sites, and that there was variation between providers. The table below summaries the average waiting times of the participant sites prior to the pilot and during the pilot (August – October 21).

	4 month average pre-pilot (days)	4 month median pre-pilot (days)	Average during pilot (days)	Average reduction in waiting times*	Median during the pilot (days)	Median reduction in waiting times*
Royal Bolton	18.70	18.13	17.67	1.03	17.5	1.2
Wrightington, Wigan & Leigh	15.75	14.88	13.75	2.00	13.42	2.33
Salford Royal	17.60	17.40	16.83	0.77	16.01	1.59
<b>Overall Pilot Sites</b>	<b>17.90</b>	<b>17.16</b>	<b>16.03</b>	<b>1.23</b>	<b>15.97</b>	<b>1.33</b>
<b>Overall variation in waiting time</b>	<b>2.95</b>	<b>4.88</b>	<b>4.37</b>	<b>2.52</b>	<b>4.00</b>	<b>1.93</b>

#### Key outcomes:

A saving of 1.33 days (median wait) to complete an EBUS equating to a 7% improvement.

Reduction in the variation of waiting times for EUS in GM of 1.93 days (60% reduction based on median wait.)

## 5. Limitations of the Pilot

There were a number of limitations within the pilot that must be considered when interpreting the results. In particular, there are a number of factors that have the potential to limit the success of the pilot and which could be overcome with a fully commissioned, GM-wide specialist cancer diagnostic digital platform.

### 5.1 Digital Integration

Infoflex® did not integrate with the existing hospital digital systems as part of the pilot due to the time and hospital resources that would be required. This meant an increase in administrative work to update two appointments systems and ensure consistency across both. This is open to human error and risks cancellations from over bookings or failure to release slot capacity.

This inability to integrate in the pilot meant that Infoflex® was solely a booking and appointments system. It did not provide the procedural report or pathology results back to the referrer. This remained an individual provider responsibility on existing processes. A GM system that provided the ability to book but also to receive reports & results could improve efficiency of the entire pathway.

### 5.2 Changing Existing Process and Pathways

The pilot faced challenges in changing individual clinician approach and existing practices. This affected engagement in the process and maximising the benefits. EUS was a small pilot compared to EBUS, but experienced limitation in that neither Salford nor Wigan moved patients to alternate sites. Bolton however, benefited the most.

Within EBUS, none of the Manchester Royal Infirmary patients were routed to earlier capacity at the Wythenshawe site, and only 21% of the Stockport patients were directed to the earlier capacity. Much of this relates, reportedly, to the complex interplay between EBUS, PET-CT, histopathology reporting and MDT practices. Alongside this pilot, work has been underway to develop a direct telephone booking service for PET-CT for Lung patients in GM. This is in place for all but MRI, Tameside & Glossop and Stockport currently.

Referrers from other organisations are able to book PET-CT scans from clinic and then align the EBUS booking in the same sitting. Without knowing the PET-CT scan date, the EBUS infoflex® system has reduced benefit.

Additionally, MRI utilises ROSE (Rapid On-Site Evaluation – a cytopathologist present in the EBUS room to give initial, provisional results on specimens) which is perceived to be more beneficial because of its rapid reporting. ROSE is not utilised at any other EBUS centre in GM, however, the ROSE reporting has limitations; it can be used for preliminary discussion at a lung cancer MDT but treatment planning decisions cannot be made without the full histology. It is not clear if ROSE reporting does facilitate earlier access for treatment. However, the perceived benefits have limited the utilisation of earlier EBUS dates, despite occasions when the waiting time was >7 days (negating the ROSE benefits). Similarly for EUS, only patients from Bolton were routed to alternate sites, and therefore the full benefit of the system was not realised.

Ultimately, the challenges of changing existing practices and process are most apparent in the sites utilised in this pilot, where the biggest impact on outcomes will therefore be seen. The pilot has ultimately only assessed the impact of single queue diagnostics in a small component of the GM population and GM assets. The impact of opening up all of GM EBUS and EUS assets to this process (potentially alongside other diagnostics) is likely to be significantly larger.

The National Lung Cancer GIRFT report is due for publication in 2022 and will recommend:

- **Specialist diagnostics in lung cancer (PET, EBUS, CT Lung Biopsy) are delivered within 5 calendar days of request.**
- **Cancer alliances co-ordinate a regional approach to managing capacity & demand & ensuring equitable access to expertise, diagnostics and treatment**
- **Where local services lacks the necessary capacity, resources should be shared across the alliance**
- **There is rejection of any resistance to change due to a perceived lack of benefit from ‘shaving off a few days here and there’ in the lung cancer pathway.**

The single queue pilot has demonstrated a framework for delivering these recommendations across a cancer alliance and delivers proof of concept for investment in a digital platform.

## 6. Conclusions

This single queue cancer diagnostic pilot is unique and has drawn the attention of cancer teams across the UK. From the outset, the ambition was to start the journey on the road to creating a specialist cancer diagnostic service with capacity that waits for patients, not that patients wait for. This would in turn create an exceptional experience of care and an efficient cancer pathway that maximises all assets within the region.

This was a limited, small-scale pilot within a selected area of GM in which basic functionality was tested; this likely under-estimates any benefits. Despite this, the pilot has demonstrated positive steps towards achieving the ambition of the Cancer Alliance for specialist cancer diagnostics and a possible blueprint for up-scaling and delivery on a regional scale to realise the huge potential this service has to offer. The key outcomes from this pilot are:

- The top priority for 75% of EBUS & 88% of EUS patients surveyed in this pilot was to have the fastest possible EBUS / EUS regardless of travelling
- 96% of EBUS & 88% of EUS patients surveyed in this pilot were 'Very Happy' or 'Happy' with the care they received
- Over half of patients completing the experience of care surveys are from the most deprived areas of GM
- The SQD EBUS service reduced waiting times for EBUS across the participating sites by 21%
- The SQD EBUS service reduced the variation in waiting times across the participating services by 42%
- The SQD EUS service reduced waiting times for EBUS across the participating sites by 7%
- The SQD EUS service reduced the variation in waiting times across the participating services by 60%
- The simple act of handing the ability to directly book EBUS procedures to referring teams improved waiting times
- In EBUS, for the referring centres that utilised earlier capacity outside of their normal referral patterns the reduction in waiting times was most significant (on average 3 days)

- **In total, the SQD EBUS service saved 350 days across the 219 patients**
- **In total, the SQD EUS service saved 66 days across the 50 patients**

These outcomes are likely the tip of the iceberg of benefit and a GM-wide specialist cancer diagnostic digital platform could significantly enhance the outcomes for cancer patients in GM. To realise these benefits the system would require the following functionality:

- **Full integration with existing digital systems to access live and accurate appointment information**
- **The ability to provide referrers with procedural reports and pathology reports as soon as they are produced and available at the host organisation**
- **The ability to book multiple specialist diagnostics simultaneously and plan complex pathways, e.g. booking PET-CT, EBUS, CT-guided lung biopsies for lung pathway patients, PET-CT and EUS for Oesophageal patients etc.**
- **Ability for patients to access bookings information, ask questions, complete user experience data.**

## **7. Next Steps**

To deliver this pilot GM Cancer have worked in collaboration with the Civica Group, utilising the functionality of Infoflex® to build single queue functionality. The pilot cost c£8000 administrative costs, GM cancer resource and a nominal fee of £30,000 charged by Civica to run the pilot and proof of concept, given the market potential of the product. The proposed next steps are to complete a case for change paper and costing for procurement of a suitable digital platform along with full digital integration.

<b>Title of paper:</b>	<b>Cancer Outcomes in Greater Manchester</b>
<b>Purpose of the paper:</b>	To provide the GM Cancer Board with an update on the latest position in relation to cancer survival in GM
<b>Summary outline of main points / highlights / issues</b>	<p>GM Cancer Board received a paper in May 2019 which set out the position at that time in relation to cancer survival in GM, with specific detail for Breast, Colorectal and Lung cancer at a National, GM and locality level</p> <p>This paper is an update on that position and includes a series of headline messages, key discussion points and recommendations to drive forward improvements in the outcome for cancer patients in GM in the context of the recovery from the Covid-19 pandemic and the development of the Integrated Care Board in GM</p>
<b>Consulted</b>	GM Cancer SMT
<b>Recommendations</b>	<p>Cancer Board members are asked to support the following recommendations:</p> <ul style="list-style-type: none"> <li>i. GM Cancer Alliance to arrange a round of locality visits to discuss in more detail and develop locality/place-based plans to address the issues identified in this report.</li> <li>ii. The above visits to be advised by the GM Cancer Pathway Boards for breast, colorectal and lung cancer in terms of appropriate actions for localities to consider.</li> <li>iii. The GM Cancer Inequalities Working Group and Early Diagnosis Steering Group to ensure the information included in this report and the outcome of the locality visits informs the work programmes for these 2 priority areas in 2022-23.</li> </ul>
<b>Authors of paper and contact details</b>	<p><b>Name:</b> Prof Dave Shackley  <b>Title:</b> Medical Director, GM Cancer Alliance  <b>Email:</b> <a href="mailto:David.shackley@nca.nhs.uk">David.shackley@nca.nhs.uk</a></p> <p><b>Name:</b> Alison Jones  <b>Title:</b> Director of Commissioning – Cancer Services (Interim)  <b>Email:</b> <a href="mailto:alison.jones8@nhs.net">alison.jones8@nhs.net</a></p>



## 2 Background & Introduction

The NHS Long Term Plan ambitions for cancer are:

**By 2028,**  
**55,000 more people each year will survive their cancer for five years**  
**75% of people with cancer will be diagnosed at an early stage (stage 1 or 2)**

Delivery of these Long Term Plan ambitions has been reiterated in the NHS Operational Planning Guidance released on 24<sup>th</sup> December 2021.

GM Cancer Board received a paper in May 2019 which set out the position at that time in relation to cancer survival in GM, with specific detail for Breast, Colorectal and Lung cancer at a National, GM and locality level.

This paper is an update on that position and includes a series of headline messages, key discussion points and recommendations to drive forward improvements in the outcome for cancer patients in GM in the context of the recovery from the Covid-19 pandemic and the development of the Integrated Care Board in GM.

## 3 The Data

The data used in this report has been sourced from national data rather than the daily download data that informs the GM Cancer PTL on Tableau. The detail of each source is outlined below.

**Survival:** The data used in this report to show the latest position on survival from cancer is taken from the National Cancer Registration and Analysis Service, which is part of Public Health England <sup>1</sup>

The data was last updated on 16<sup>th</sup> November 2021 and is: *Cancer Survival in England for patients diagnosed between 2014 and 2018 followed up until 2019.*

It should be noted that the national data excludes children's cancer and prostate cancer, and so is of limited benefit in international benchmarking. The data is also approximately 2 years out of date, in terms of the real time outcomes experienced today. This will be a particular issue when considering the current position given the impact of the Covid-19 pandemic.

**Staging:** The staging data used in this report is from the National Cancer Registration and Analysis Service (**NCRAS**)<sup>2</sup>

<sup>1</sup> [Cancer survival in England for patients diagnosed between 2014 and 2018, and followed up to 2019](https://www.gov.uk/government/statistics/cancer-survival-in-england-for-patients-diagnosed-between-2014-and-2018-and-followed-up-to-2019) - GOV.UK ([www.gov.uk](http://www.gov.uk))

<sup>2</sup> [https://www.cancerdata.nhs.uk/stage\\_at\\_diagnosis](https://www.cancerdata.nhs.uk/stage_at_diagnosis)

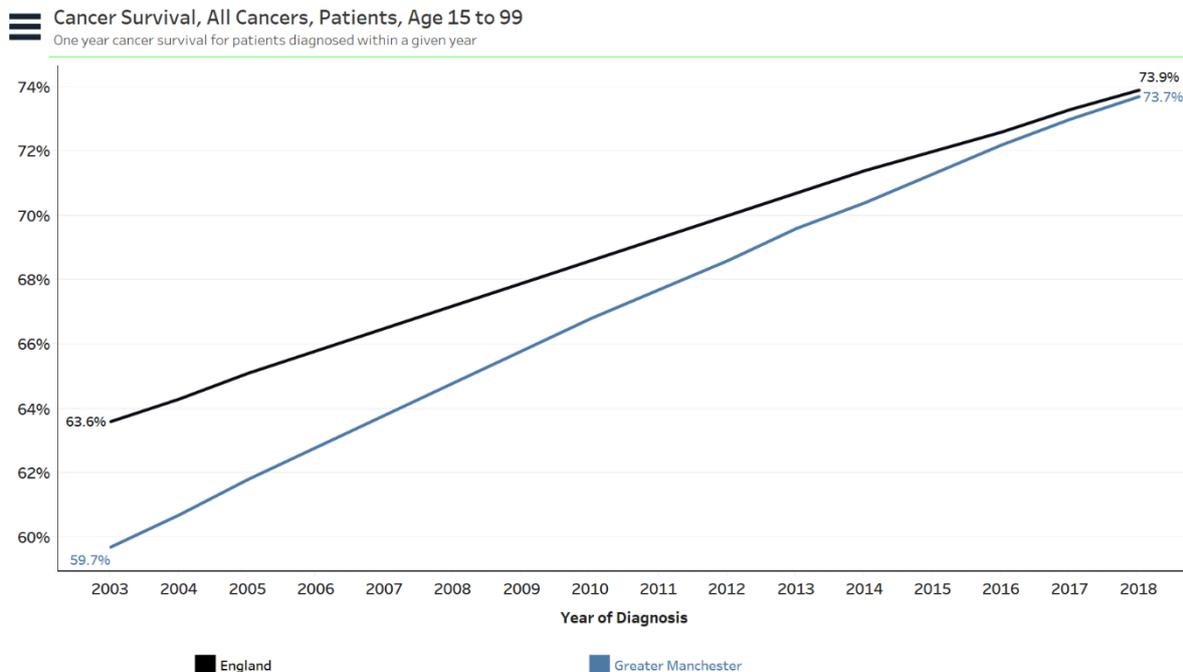


## 4 Key Discussion Points

### i. Headline Observations – Survival

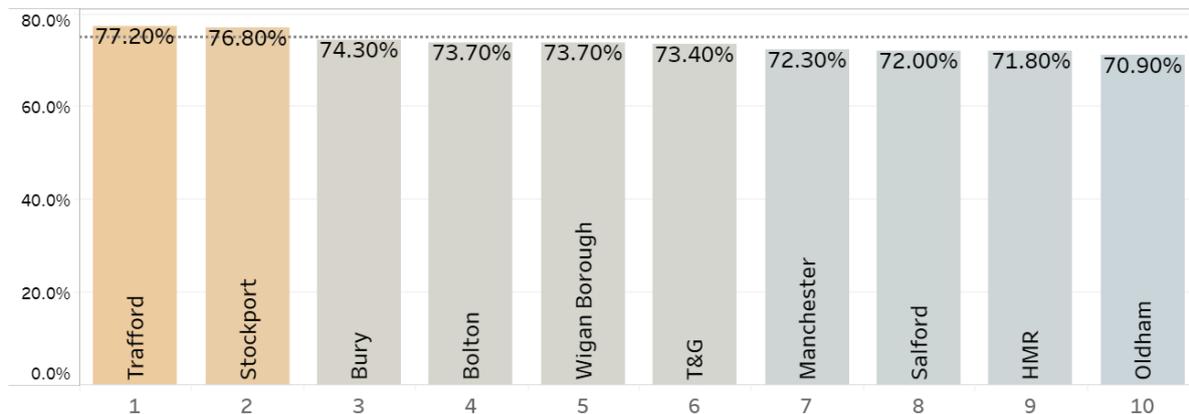
In the GM Cancer Board paper presented in May 2019 the 1-year cancer survival for Greater Manchester was 72.1% based on patients diagnosed in the calendar year 2016 compared to a national figure of 72.8%.

The chart below shows that the current position based on the latest national data is a 1-year survival rate for all cancers of 73.7% compared to a national (England) figure of 73.9%. GM have closed the gap in terms of the position against the national figure – in the previous report the gap was 0.7% but using the latest data this gap is 0.2% and a continued improvement trajectory is evident below.



The data is available at CCG level. The variation across the 10 CCGs / Localities in Greater Manchester can therefore be analysed and seen below. There is **variation across GM** ranging from 70.9% in Oldham to 77.2% in Trafford.





In Appendix 1 to this report is a detailed breakdown of the position of each CCG / Locality for 1 year survival. What can be seen is:

- All 10 localities have continued to improve with 1-year survival for all cancers
- There are 5 localities in GM where the 1-year survival is equal to or greater than the GM average (Bolton, Bury, Stockport, Trafford, Wigan)
- There are **3 localities who are higher than the England average** (Bury, Stockport and Trafford) with Stockport and Trafford in the top 4 nationally
- However
- There are 2 localities where the **improvement has been less than the improvement across GM** as a whole – so the gap between that locality and the GM position has widened – these are
  - Heywood Middleton & Rochdale
  - Salford
- The position of the remaining 8 localities **relative to the GM average has improved** or been maintained
- The locality with the greatest improvement relative to the GM average since the last report to GM Cancer Board in 2019 is Trafford CCG with a 0.6% relative improvement

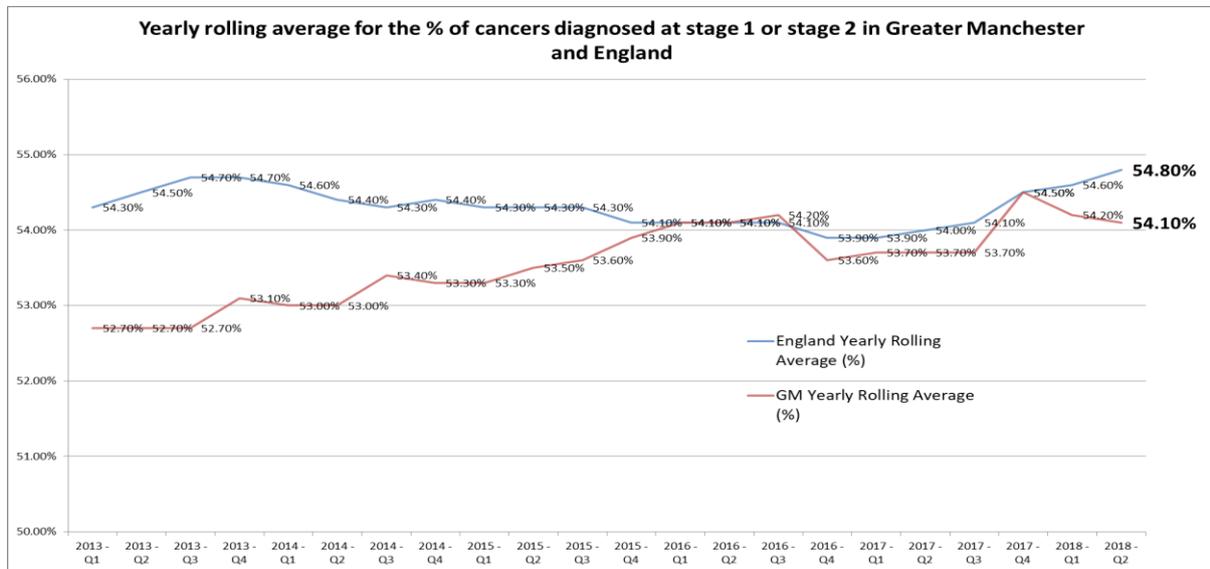
## ii. Headline Observations – Stage at Diagnosis

The NHS Long Term Plan ambition is for 75% of cancers to be diagnosed at stage 1 or 2 by 2028.

The position in GM has improved over the past 8 years but is still only at 53.8% compared with a national position of 54.5%.

This presents a significant challenge for GM to reach the target of 75% in 6 years time. The chart below shows the previous improvement over time against this standard – for GM and nationally.





There is also variation across the 10 GM localities where the position ranges from 51.7% (Oldham) to 57.0% (Heywood Middleton & Rochdale).

**GM Cancer Staging Report**  
**Stage at Diagnosis Report**

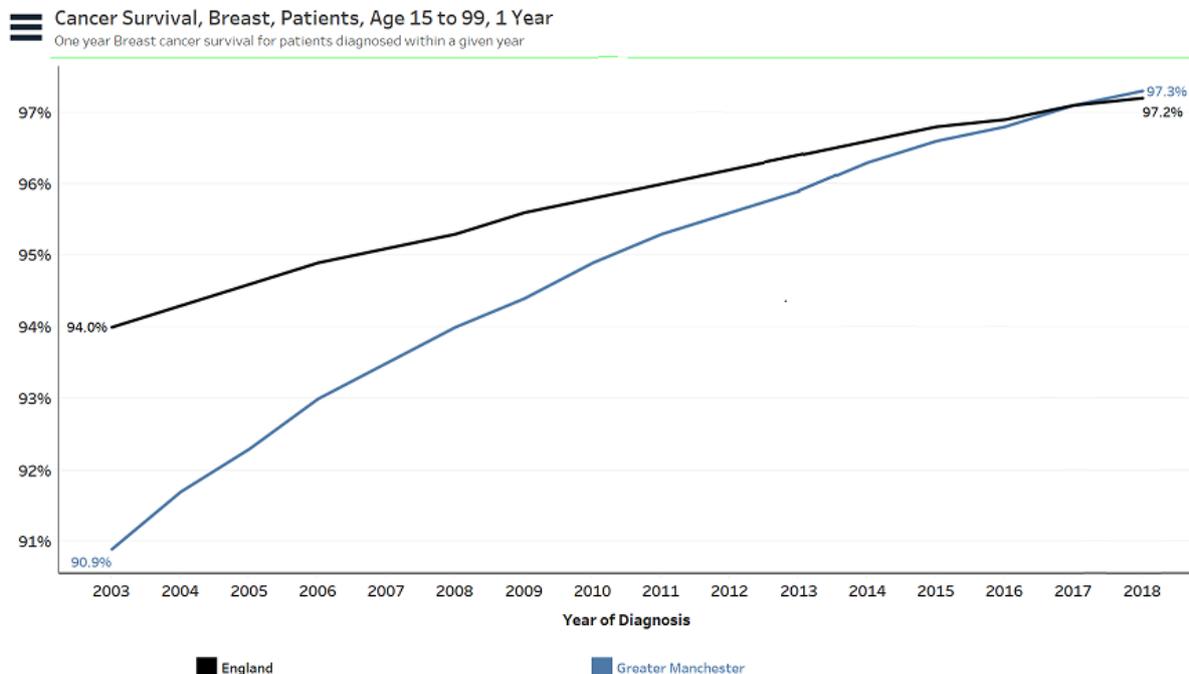
**Stage at Diagnosis - Early Stage % Performance**  
Cancer Sites: All

	2013	2014	2015	2016	2017	2018	2019
National	54.3%	54.6%	54.3%	54.1%	53.9%	54.4%	54.5%
Greater Manchester	52.7%	53.0%	53.4%	54.1%	53.6%	54.1%	53.8%
NHS Bolton CCG	55.0%	54.1%	53.2%	56.7%	56.5%	53.5%	54.8%
NHS Bury CCG	51.8%	55.3%	51.8%	56.3%	54.2%	54.9%	55.9%
NHS Heywood, Middleton and Rochdale CCG	51.8%	54.0%	53.6%	52.3%	54.9%	53.4%	57.0%
NHS Manchester CCG	51.3%	49.1%	50.8%	50.7%	51.8%	53.7%	52.8%
NHS Oldham CCG	50.5%	53.4%	51.6%	53.4%	52.9%	53.6%	51.7%
NHS Salford CCG	53.2%	53.8%	52.2%	53.0%	50.0%	51.9%	52.9%
NHS Stockport CCG	52.5%	55.0%	55.6%	55.8%	54.9%	54.9%	54.4%
NHS Tameside and Glossop CCG	51.3%	48.8%	53.7%	54.1%	53.3%	54.1%	53.6%
NHS Trafford CCG	58.3%	54.5%	58.0%	54.7%	54.8%	56.2%	54.5%
NHS Wigan Borough CCG	51.8%	54.2%	53.8%	55.3%	53.3%	54.5%	52.1%

**iii. Breast Cancer in GM**

The latest data for breast cancer survival in GM can be seen in the chart below and shows that over the past 2 reported years there has been significant progress in GM moving from

below to above the England average. The GM average is now 97.3% against an England position of 97.2%.



In **Appendix 1** to this report is a detailed breakdown of the position of each CCG / Locality for 1 year **breast cancer survival**. What can be seen is:

- All 10 localities have continued to improve with 1-year survival for breast cancers but to significantly varying degrees over time and in comparison to GM and England
- There are 4 localities in GM where the 1-year survival is **equal to or greater than the GM average** (Bolton, Manchester, Stockport, Trafford)
- GM has seen a 0.5% improvement in 1-year survival since the previous report to the GM Cancer Board in 2019. This trajectory has been matched by most localities with 0.4/0.5% improvement in 8 of the 10
- The improvement over the past 2 years in Salford has been 0.2%
- The locality with the **greatest improvement relative to the GM average** since the last report to GM Cancer Board in 2019 is **Tameside & Glossop CCG** with a 0.7% relative improvement
- The locality with the least improvement over the past 8 years is Wigan where there has only been an 0.8% improvement since 2010 compared with an improvement of 2.4% at a GM level over the same time period



Greater Manchester Cancer GM Cancer Staging Report  
**Stage at Diagnosis Report**

**Stage at Diagnosis - Early Stage % Performance**  
Cancer Sites: Breast

	2013	2014	2015	2016	2017	2018	2019
National	84.4%	85.0%	85.0%	85.5%	85.3%	85.4%	85.7%
Greater Manchester	81.5%	83.4%	82.5%	83.7%	83.4%	83.2%	82.9%
NHS Bolton CCG	88.5%	84.5%	87.1%	84.1%	85.0%	79.9%	84.5%
NHS Bury CCG	79.7%	81.8%	82.4%	85.7%	79.3%	85.8%	85.5%
NHS Heywood, Middleton and Rochdale CCG	85.7%	81.1%	84.4%	81.3%	85.7%	80.0%	83.8%
NHS Manchester CCG	81.2%	83.0%	84.9%	79.9%	79.3%	82.4%	83.8%
NHS Oldham CCG	77.5%	80.1%	82.4%	84.6%	84.1%	87.0%	81.7%
NHS Salford CCG	83.0%	88.8%	75.9%	87.7%	87.9%	84.8%	86.4%
NHS Stockport CCG	78.6%	88.7%	85.1%	86.8%	83.5%	84.0%	79.2%
NHS Tameside and Glossop CCG	82.5%	82.7%	78.3%	84.0%	88.6%	83.3%	80.6%
NHS Trafford CCG	84.6%	81.9%	85.1%	81.5%	79.6%	81.4%	83.7%
NHS Wigan Borough CCG	76.7%	80.5%	78.6%	82.4%	83.4%	83.8%	82.7%

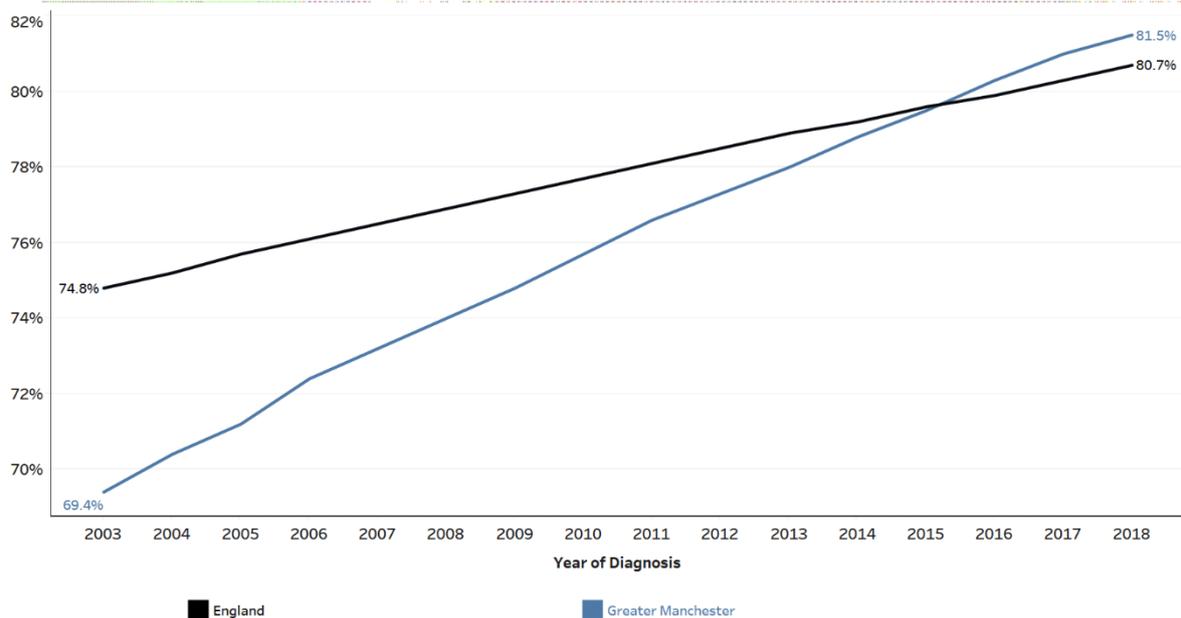
The data above shows that from a breast cancer perspective in GM, 82.9% are diagnosed at stage 1 or 2 compared to an England average of 85.7%. There is variation across the 10 localities from 79.2% (Stockport) to 86.4% (Salford). As set out in the introduction to this paper, the expectation is that 75% of all cancers should be diagnosed at stage 1 or 2 by 2028.

**iv. Colorectal Cancer in GM**

The latest data for colorectal cancer survival in GM can be seen in the chart below and shows that over the past 2 reported years there has been significant progress in GM moving further above the England average. The GM average is now 81.5% against an England position of 80.7%. At a national level the improvement since 2003 has been 5.9% whereas for GM the improvement has been 12.1% and the gap between the GM position and the England position continues to grow.



■ Cancer Survival, Colorectal, Patients, Age 15 to 99, 1 Year  
One year Colorectal cancer survival for patients diagnosed within a given year



In **Appendix 1** to this report is a detailed breakdown of the position of each CCG / Locality for 1-year **colorectal cancer survival**. What can be seen is:

- Of the 10 localities, 9 have continued to improve with 1-year survival for colorectal cancers and 1 has a slight decrease in the 2018 data. However, the improvement across GM has been to significantly varying degrees over time and in comparison to GM and England
- There are 4 localities in GM where the 1-year survival is **LESS than the GM average** (Heywood Middleton and Rochdale (HMR), Manchester, Oldham, Salford). The 1-year survival rate in HMR is 76% therefore 5.5% less than the GM average.
- GM has seen a 1.2% improvement in 1-year survival since the previous report to the GM Cancer Board in 2019.
- This improvement trajectory has been matched or exceeded by 5 localities
- The locality with the **greatest improvement relative to the GM average** since the last report to GM Cancer Board in 2019 is **Tameside & Glossop CCG** with a 2.1% improvement over 2 years and with the highest rate of 1-year survival for colorectal cancer in GM with 85.1%
- The locality with the **least improvement over the past 2 years is HMR** where there has only been a 0.6% improvement

Greater Manchester Cancer GM Cancer Staging Report  
**Stage at Diagnosis Report**

**Stage at Diagnosis - Early Stage % Performance**  
Cancer Sites: Colon

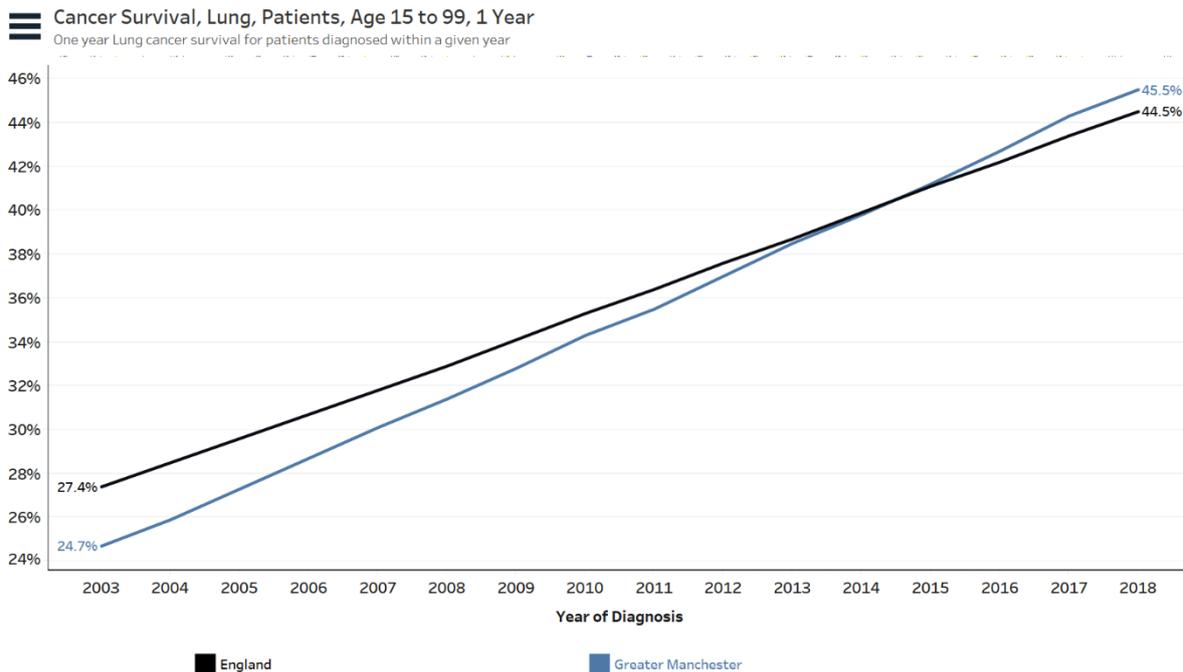
	2013	2014	2015	2016	2017	2018	2019
National	45.2%	45.0%	45.2%	45.1%	44.5%	45.0%	45.9%
Greater Manchester	47.1%	45.4%	44.9%	46.3%	44.5%	45.0%	46.8%
NHS Bolton CCG	60.2%	52.7%	41.9%	57.0%	48.0%	49.6%	49.5%
NHS Bury CCG	39.0%	55.0%	39.4%	52.6%	37.5%	56.0%	49.4%
NHS Heywood, Middleton and Rochdale CCG	59.0%	46.9%	41.0%	42.9%	47.9%	53.3%	58.3%
NHS Manchester CCG	43.1%	36.7%	44.1%	40.2%	44.2%	38.3%	43.9%
NHS Oldham CCG	34.8%	42.0%	40.5%	38.5%	47.6%	37.4%	44.1%
NHS Salford CCG	47.2%	45.6%	43.8%	51.9%	38.0%	42.2%	41.8%
NHS Stockport CCG	41.5%	42.3%	49.6%	43.9%	49.6%	43.5%	42.6%
NHS Tameside and Glossop CCG	48.1%	48.6%	55.6%	56.7%	39.7%	48.3%	50.5%
NHS Trafford CCG	50.7%	41.4%	46.4%	37.5%	43.2%	41.0%	44.9%
NHS Wigan Borough CCG	49.3%	46.0%	41.8%	43.9%	46.3%	45.5%	48.5%

The data above shows that 46.8% of colorectal cancers in GM are diagnosed at stage 1 or 2 compared to an England average of 45.9%. The position in relation to stage at diagnosis in GM has deteriorated from 47.1% in 2013. There is variation across the 10 localities from 41.8% (Salford) to 58.3% (HMR). As set out in the introduction to this paper, the expectation is that 75% of all cancers should be diagnosed at stage 1 or 2 by 2028.



## v. Lung Cancer in GM

The latest data for lung cancer survival in GM can be seen in the chart below and shows that over the last 2 reported years there has been significant progress in GM moving further above the England average. The GM average is now 45.5% against an England position of 44.5%. At a national level the improvement since 2003 has been 17.1% whereas for GM the improvement has been 20.8% and the gap between the GM position and the England position continues to grow.



Data Source: NCRAS Produced by GM Cancer. Please ask for permission to share outside of agreed upon situations.

In **Appendix 1** to this report is a detailed breakdown of the position of each CCG / Locality for 1-year **lung cancer survival**. What can be seen is:

- The GM figure has been **above the England figure for the last 4 years** and has improved by 2.8% since the last Board report in 2019 (1.2% since the last data was released in 2020).
- This improvement trajectory (1.2%) has been matched or exceeded by 8 localities
- All 10 localities have continued to improve with 1-year survival for lung cancers with
- There are 6 localities in GM where the 1-year survival is **LESS than the GM average** (Bury, Heywood Middleton and Rochdale (HMR), Oldham, Salford, Tameside & Glossop and Wigan).
- There is significant variation across the 10 localities in GM with a difference of 15% between the highest (Trafford 54.7%) and lowest (Heywood Middleton & Rochdale 39.7%)
- The locality with the **greatest improvement relative to the GM average** between 2020 (2016) and 2021(2018) is **Tameside & Glossop CCG** with a 2.1% improvement
- The localities with the **least improvement over the past year** are **Bolton and Wigan** where there has only been a 0.9% improvement

GM Cancer Staging Report  
**Stage at Diagnosis Report**

**Stage at Diagnosis - Early Stage % Performance**  
 Cancer Sites: Lung

	2013	2014	2015	2016	2017	2018	2019
National	23.8%	25.4%	26.4%	28.1%	29.5%	29.1%	30.4%
Greater Manchester	28.7%	28.4%	28.1%	34.9%	36.6%	33.6%	36.1%
NHS Bolton CCG	32.5%	30.3%	27.0%	35.3%	40.4%	31.8%	33.3%
NHS Bury CCG	25.8%	32.1%	24.7%	33.5%	41.3%	28.5%	34.8%
NHS Heywood, Middleton and Rochdale CCG	28.0%	28.5%	28.2%	26.0%	34.7%	32.4%	27.3%
NHS Manchester CCG	32.3%	31.1%	26.3%	36.1%	42.3%	42.6%	43.0%
NHS Oldham CCG	30.6%	26.2%	26.8%	36.6%	26.7%	28.7%	30.6%
NHS Salford CCG	31.9%	25.4%	28.3%	34.2%	31.9%	31.2%	40.2%
NHS Stockport CCG	24.0%	31.8%	34.4%	36.6%	37.9%	33.7%	38.6%
NHS Tameside and Glossop CCG	21.5%	26.4%	27.5%	35.2%	34.2%	27.2%	38.3%
NHS Trafford CCG	37.0%	26.8%	34.0%	41.2%	43.4%	41.7%	38.9%
NHS Wigan Borough CCG	24.6%	25.4%	26.7%	33.3%	31.8%	30.5%	29.6%

The data above shows that 36.1% of lung cancers in GM are diagnosed at stage 1 or 2 compared to an England average of 30.4%. There is variation across the 10 localities in GM from 27.3% (HMR) to 43% (Manchester) followed by Salford at 40.2%. It should be noted that Manchester and Salford have been running the Targeted Lung Health Checks projects during the time covered by the most recent data. As set out in the introduction to this paper, the expectation is that 75% of all cancers should be diagnosed at stage 1 or 2 by 2028.

**vi. Locality Variation and Demographic Influences**

As outlined in the sections above there is significant variation across the 10 localities in GM. Alongside the pathway specific and ‘all cancer’ data shown in this report, the Cancer Alliance has also developed data at a locality level which in addition to the survival and staging data shows:

- Ethnicity of registered / resident population
- Deprivation indices of the 10 localities
- Inequalities data: Referrals and first treatments by age, ethnicity, gender and deprivation
- Cancer diagnoses as a result of an emergency presentation
- Cancer Waiting Times performance (62 day)



- Suspected Cancer Referrals per 100k population

A report is in development which allows interrogation of the data at a GM, England and locality level for the above.

## 5 Recommendations

Cancer Board members are asked to support the following recommendations:

- GM Cancer Alliance to arrange a round of locality visits to discuss in more detail and develop locality/place-based plans to address the issues identified in this report.
- The above visits to be advised by the GM Cancer Pathway Boards for breast, colorectal and lung cancer in terms of appropriate actions for localities to consider.
- The GM Cancer Inequalities Working Group and Early Diagnosis Steering Group to ensure the information included in this report and the outcome of the locality visits informs the work programmes for these 2 priority areas in 2022-23.



## Appendix 1: Locality / CCG Detail

### 1 Year Survival - All Cancers

GM Cancer CCG KPI Summary  
**Enhanced Pathway Board Key Indicator Report**

**Cancer Survival, All Cancers, Patients, Age 15 to 99 Performance**

Measure Name	Most Recent Position		Comparators		Comparators Locality - National
	Most Recent Period	Most Recent Performance	Previous Period - National	Locality - National	
Greater Manchester	2018	73.7%	+0.7% ▲ 2017: 73.0%	-0.2% ▼ National: 73.9%	
NHS Bolton CCG	2018	73.7%	+0.8% ▲ 2017: 72.9%	-0.2% ▼ National: 73.9%	
NHS Bury CCG	2018	74.3%	+1.1% ▲ 2017: 73.2%	+0.4% ▲ National: 73.9%	
NHS Heywood, Middleton And Rochdale CCG	2018	71.8%	+0.6% ▲ 2017: 71.2%	-2.1% ▼ National: 73.9%	
NHS Manchester CCG	2018	72.3%	+0.7% ▲ 2017: 71.6%	-1.6% ▼ National: 73.9%	
NHS Oldham CCG	2018	70.9%	+0.8% ▲ 2017: 70.1%	-3.0% ▼ National: 73.9%	
NHS Salford CCG	2018	72.0%	+0.6% ▲ 2017: 71.4%	-1.9% ▼ National: 73.9%	
NHS Stockport CCG	2018	76.8%	+0.6% ▲ 2017: 76.2%	+2.9% ▲ National: 73.9%	
NHS Tameside And Glossop CCG	2018	73.4%	+1.0% ▲ 2017: 72.4%	-0.5% ▼ National: 73.9%	
NHS Trafford CCG	2018	77.2%	+0.8% ▲ 2017: 76.4%	+3.3% ▲ National: 73.9%	
NHS Wigan Borough CCG	2018	73.7%	+0.6% ▲ 2017: 73.1%	-0.2% ▼ National: 73.9%	

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# 1 Year Survival - Breast Cancer

GM Cancer CCG KPI Summary  
**Enhanced Pathway Board Key Indicator Report**

☰ Cancer Survival, Breast, Patients, Age 15 to 99, 1 Year Performance

Measure Name	Most Recent Position		Comparators		Comparators Locality - National
	Most Recent Period	Most Recent Performance	Previous Period - National	Locality - National	
Greater Manchester	2018	97.3%	+0.2% ▲ 2017: 97.1%	+0.1% ▲ National: 97.2%	
NHS Bolton CCG	2018	97.3%	+0.2% ▲ 2017: 97.1%	+0.1% ▲ National: 97.2%	
NHS Bury CCG	2018	96.5%	+0.3% ▲ 2017: 96.2%	-0.7% ▼ National: 97.2%	
NHS Heywood, Middleton And Rochdale CCG	2018	96.6%	+0.1% ▲ 2017: 96.5%	-0.6% ▼ National: 97.2%	
NHS Manchester CCG	2018	97.4%	+0.2% ▲ 2017: 97.2%	+0.2% ▲ National: 97.2%	
NHS Oldham CCG	2018	96.0%	+0.2% ▲ 2017: 95.8%	-1.2% ▼ National: 97.2%	
NHS Salford CCG	2018	96.1%	+0.1% ▲ 2017: 96.0%	-1.1% ▼ National: 97.2%	
NHS Stockport CCG	2018	98.6%	+0.2% ▲ 2017: 98.4%	+1.4% ▲ National: 97.2%	
NHS Tameside And Glossop CCG	2018	96.8%	+0.3% ▲ 2017: 96.5%	-0.4% ▼ National: 97.2%	
NHS Trafford CCG	2018	98.3%	+0.2% ▲ 2017: 98.1%	+1.1% ▲ National: 97.2%	
NHS Wigan Borough CCG	2018	95.7%	0% 2017: 95.7%	-1.5% ▼ National: 97.2%	

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# 1 Year Survival - Colorectal Cancer

GM Cancer CCG KPI Summary  
**Enhanced Pathway Board Key Indicator Report**

**Cancer Survival, Colorectal, Patients, Age 15 to 99, 1 Year Performance**

Measure Name	Most Recent Position		Comparators		Comparators Locality - National
	Most Recent Period	Most Recent Performance	Previous Period - National	Locality - National	
Greater Manchester	2018	81.5%	+0.5% ▲ 2017: 81.0%	+0.8% ▲ National: 80.7%	
NHS Bolton CCG	2018	83.4%	+1.1% ▲ 2017: 82.3%	+2.7% ▲ National: 80.7%	
NHS Bury CCG	2018	83.2%	+0.4% ▲ 2017: 82.8%	+2.5% ▲ National: 80.7%	
NHS Heywood, Middleton And Rochdale CCG	2018	76.0%	-0.5% ▲ 2017: 75.5%	-4.7% ▼ National: 80.7%	
NHS Manchester CCG	2018	77.5%	+0.8% ▲ 2017: 76.7%	-3.2% ▼ National: 80.7%	
NHS Oldham CCG	2018	76.5%	+0.5% ▲ 2017: 76.0%	-4.2% ▼ National: 80.7%	
NHS Salford CCG	2018	80.1%	+0.1% ▲ 2017: 80.0%	-0.6% ▼ National: 80.7%	
NHS Stockport CCG	2018	84.0%	-0.5% ▼ 2017: 84.5%	+3.3% ▲ National: 80.7%	
NHS Tameside And Glossop CCG	2018	85.1%	+1.0% ▲ 2017: 84.1%	+4.4% ▲ National: 80.7%	
NHS Trafford CCG	2018	81.5%	+1.0% ▲ 2017: 80.5%	+0.8% ▲ National: 80.7%	
NHS Wigan Borough CCG	2018	82.5%	+0.2% ▲ 2017: 82.3%	+1.8% ▲ National: 80.7%	

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# 1 Year Survival - Lung Cancer

GM Cancer CCG KPI Summary  
**Enhanced Pathway Board Key Indicator Report**

☰ Cancer Survival, Lung, Patients, Age 15 to 99, 1 Year Performance

Measure Name	Most Recent Position		Comparators		Comparators Locality - National
	Most Recent Period	Most Recent Performance	Previous Period - National	Locality - National	
Greater Manchester	2018	45.5%	+1.2% ▲ 2017: 44.3%	+1.0% ▲ National: 44.5%	
NHS Bolton CCG	2018	45.8%	+0.9% ▲ 2017: 44.9%	+1.3% ▲ National: 44.5%	
NHS Bury CCG	2018	42.2%	+1.2% ▲ 2017: 41.0%	-2.3% ▼ National: 44.5%	
NHS Heywood, Middleton And Rochdale CCG	2018	39.7%	+1.7% ▲ 2017: 38.0%	-4.8% ▼ National: 44.5%	
NHS Manchester CCG	2018	47.5%	+1.2% ▲ 2017: 46.3%	+3.0% ▲ National: 44.5%	
NHS Oldham CCG	2018	43.8%	+1.6% ▲ 2017: 42.2%	-0.7% ▼ National: 44.5%	
NHS Salford CCG	2018	45.1%	+1.3% ▲ 2017: 43.8%	+0.6% ▲ National: 44.5%	
NHS Stockport CCG	2018	50.3%	+1.6% ▲ 2017: 48.7%	+5.8% ▲ National: 44.5%	
NHS Tameside And Glossop CCG	2018	43.8%	+2.1% ▲ 2017: 41.7%	-0.7% ▼ National: 44.5%	
NHS Trafford CCG	2018	54.7%	+1.4% ▲ 2017: 53.3%	+10.2% ▲ National: 44.5%	
NHS Wigan Borough CCG	2018	43.0%	+0.9% ▲ 2017: 42.1%	-1.5% ▼ National: 44.5%	

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<b>Title of paper:</b>	<b>Greater Manchester Cancer Tackling Inequalities Action Plan</b>
<b>Purpose of the paper:</b>	To provide an update on the actions in place to deliver the GM Cancer Strategy for addressing inequalities
<b>Summary outline of main points / highlights / issues</b>	<p>The attached document provides an update on actions relating to:</p> <ul style="list-style-type: none"> <li>• User Involvement</li> <li>• GM system engagement: VCSE</li> <li>• Reducing the Risk of Cancer / Prevention</li> <li>• Research</li> <li>• Early Diagnosis &amp; Primary Care Networks</li> <li>• GM Cancer Alliance: Projects &amp; Governance (data, diagnostics and treatment)</li> <li>• Single Queue Diagnostics and Consolidation of Oncology Outpatient Provision</li> <li>• Workforce</li> <li>• GM System Engagement: CCGs / Localities</li> </ul> <p>The Cancer Alliance will progress these plans and will ensure the 2022-23 response to the national planning guidance includes details of identifying and addressing inequalities in cancer care – referral and treatment</p>
<b>Consulted</b>	GM Cancer inequalities working group GM Community Co-ordination Cell GM CCG Cancer Commissioning Managers
<b>Recommendations</b>	To note the content of the attached action plan and agree this as a way forward for the GM Cancer work on inequalities
<b>Authors of paper and contact details</b>	<p><b>Name:</b> Alison Jones  <b>Title:</b> Director of Commissioning – Cancer Services (Interim)  <b>Email:</b> <a href="mailto:alison.jones8@nhs.net">alison.jones8@nhs.net</a></p>





## Greater Manchester Cancer Tackling Inequalities Action Plan

<b>Document Title:</b>	Greater Manchester Cancer: Tackling Inequalities Strategy
<b>Version:</b>	4.0
<b>Author:</b>	Alison Jones
<b>Authors Title:</b>	Interim Director of Commissioning – GM Cancer / GM Joint Commissioning Team
<b>Consultation Group:</b>	Greater Manchester Cancer Inequalities Steering Group
<b>Date Ratified:</b>	V4.0 March 2022
<b>Review Date:</b>	Ongoing

## Introduction

Health inequalities in cancer refer to avoidable differences in the cancer care that people receive, and the opportunities people have to lead health lives, free of cancer. Such inequality has been established for some time and relates in many cases to definable disadvantaged groups. To reduce such cancer-related outcome/experience differences, we must focus more attention on those who are at greater risk of developing cancer, and those who are less likely to survive the disease. GM Cancer Board approved a 'GM Cancer Tackling Inequalities Strategy' in September 2021, with the recommendation that a clear list of actions to support the delivery of the strategy was produced and taken forward, with named leads and clear timescales / deadlines. This action plan is based on the original strategy document and the revised work plan / priorities included and summarised below.

User Involvement

GM system engagement: VCSE

Reducing the Risk of Cancer / Prevention

Research

Early Diagnosis & Primary Care Networks

GM Cancer Alliance: Projects & Governance (data, diagnostics and treatment)

Single Queue Diagnostics and Consolidation of Oncology Outpatient Provision

Workforce

GM System Engagement: CCGs / Localities

## GM System Engagement: VCSE

During summer 2021 GM Cancer commissioned GMCVO to undertake a project focused on inequalities in cancer outcomes amongst marginalised communities. To this end, GMCVO have brought together a steering group comprised of representatives voluntary, community and social enterprise (VCSE) groups to guide the programme. That group, along with conversation with GM Cancer, have guided delivery of the projects across three areas.

Project/Work area	Aim	Objective/Output	Owner & Timeframe
User Involvement Programme	The user involvement programme has diverse membership with people from a range of backgrounds, particularly those who experience poorer outcomes	Review existing membership data  Support development of refreshed recruitment and induction processes, including training	Beth Sharratt, GMCVO
Tackling inequalities in cancer care and outcomes	<b>A robust, evidence-based picture of the barriers faced and actions to mitigate them is available to the cancer system and feeds into Tackling Inequalities strategy</b>	Gather intelligence and research on barriers Create portfolio of good practice in GM & beyond Recommendations for the cancer system	Beth Sharratt, GMCVO
Strategic involvement with the VCSE sector	There is meaningful engagement between the GM cancer system and VCSE sector which supports to achieve our shared outcomes in terms of reducing inequalities, in line with the <a href="#">VCSE Accord</a>	Review of existing and previous engagement work Proposal paper for future engagement with the VCSE sector	Beth Sharratt, GMCVO
<b>Update (add date):</b>	<b>March 2022:</b> Ongoing collation of data on inequalities in cancer for different groups protected under the Equality Act sorted according to the headings in the GM Tackling Inequalities Strategy: User Involvement, Prevention, Research, Early Diagnosis & Primary Care, Personalised Care, GM Cancer Alliance, and Workforce. Suggested action to address the inequalities under each heading is included.		

	<p>Data sources include academic articles, research reports, existing national guidance, and interviews with GM VCSE sector organisations, which support people with cancer. This work will be reviewed and finalised in a workshop with VCSE organisations in late March. We have had conversations many colleagues within GM Cancer to help inform our work and understand how best to embed the learning an evidence that emerges. These have included discussions with the Personalised Care team about the intersection between personalised care and tackling systemic inequalities and the need for a coordinated approach via the tackling inequalities strategy.</p> <p>Proposals for future engagement of VCSE sector organisations are being drawn up in parallel with the desk research and interviews. These will be developed and finalised in discussion with key VCSE partners and GM Cancer in late March/early April. A group drawn from the <a href="#">GM VCSE Leadership Group</a> will support this strand of the work, bringing the legacy of the project and ongoing relationship with the VCSE sector under the banner of the VCSE Accord.</p> <p>Additional work to support diversification of the User Involvement Programme will be scoped by early March.</p>
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User involvement			
Project/Work area	Aim	Objective/Output	Owner & Timeframe
GM Cancer UI network membership	GM Cancer UI team to work with GM system to expand membership of the cancer UI network to ensure a broad and diverse representation which reflects the GM population	UI network for GM cancer representative of the GM population	Sinead Collins, GM Cancer UI
Health Inequalities Working Group membership	To include UI representation within the membership of the GM Cancer Inequalities Working Group, ensuring members are able to support discussions on	Identified member(s) for the Steering Group and therefore UI engagement in the ongoing development and implementation of the strategy and action plan	Ali Jones / Sinead Collins, GM Cancer

	how to identify and address inequalities.		
<b>Update (add date):</b>	<b>March 2022:</b> work progressing with VCSE as per update above		

### Reducing Risk of Cancer / Prevention

Project/Work area	Aim	Objective/Output	Owner & Timeframe
System projects on prevention of cancer	GM Cancer and system partners will actively explore new smoking cessation and prehab initiatives to leverage opportunities to reduce inequalities, recognising that CURE, Prehab4Cancer and Targeted Lung Health Check (TLHC) programmes have previously been effective vehicles to reduce health inequalities	Identified and confirmed projects to support this agenda – in place with appropriate system engagement  <i>Advocate for more preventative work</i>	Dave Shackley/Ali Jones/Debs Thompson
<b>Update (add date):</b>	<p><b>March 2022:</b> Further discussion between Cancer Alliance, Section 7a screening commissioning team and population health to progress joint working and links with CORE20PLUS5</p> <p>Feedback from GM Community Co-ordination Cell to request a focus on prevention via the cancer inequalities work</p> <p>Progress being made with discussions to extend the TLHC offer in GM in line with national planning guidance</p>		

### Research

Project/Work area	Aim	Objective/Output	Owner & Timeframe
Inclusive, equitable and diverse research	Drive best precision in our clinical trials based on orthogonal data derived from diverse populations in Greater Manchester (GM) and in so doing, ensure our research is equitable, diverse and inclusive	Quantify the current enrolment to trials based on patient demographics. Understand the barriers to enrolment to trials from diverse populations.	Rob Bristow / Sinead Savage
	Devise inclusive research programmes focusing on health inequalities, including expanding our pre-clinical models to represent diverse populations	Obtain funding for basic and translational research projects with a particular focus on reflecting Manchester's diverse populations.	Rob Bristow / Sinead Savage
<b>Update (add date):</b>	<b>March 2022:</b> SS spoke with Radiographers from the Christie who are developing a questionnaire to understand barriers to trial enrolment in their patients. SS also suggested that the working group could discuss methods to capture patient demographics in different trusts, to understand if there are methods that could be shared across trusts.		

Early Diagnosis & Primary Care Networks			
Project/Work area	Aim	Objective/Output	Owner & Timeframe
Primary Care Networks	Engage the 67 PCNs in Greater Manchester in the Early Diagnosis work of the Cancer Alliance and align with the PCN DESs on Early Diagnosis and Inequalities	Address variation in early diagnosis of cancer	Ali Jones, GM Cancer

Screening	Work jointly with partners in the GM system to address variation in the uptake of cancer screening programmes	Improve screening uptake, addressing inequalities in uptake	Amy Ashton, GMHSCP Jonny Hirst and Donna Miller, Answer Cancer  Ali Jones, GM Cancer (via PCN network and CCG commissioning leads)
Patient facing communications	Ensure patient facing communication in relation to early presentation and diagnosis is targeted in the geographies / communities and pathways where there is greatest need and variation	Targeted programme of communication and engagement work delivered Additional and tailored support to meet the needs of specific communities and patient groups in GM	Anna Perkins/Ali Jones, GM Cancer
Homelessness and Health	Joint programme of work between GM Cancer / JCT and the Strategic Relationship Manager (Housing) for GM Health & Social Care Partnership	To identify opportunities through the 'homelessness and health' programme to support early diagnosis of cancer within the homeless community in Greater Manchester	Ali Jones / Helen Simpson
Rapid Diagnostic Centres	GM population wide access to Non-Site Specific RDC pathway to ensure equity of access to RDC pathways  Ensure design and delivery of RDC pathways targets population groups who don't always present with potential cancer symptoms	31/3/2022 deadline in GM for this to be in place across all 10 localities in GM  Work through localities to identify and engage all population groups to ensure equality of access	Sue Sykes, GM Cancer RDC Programme Manager

Lower GI Pathway / FIT compliance	Work on professional and patient facing communications to ensure compliance with the FIT part of the lower GI pathway	Production of patient facing information in multiple format and languages (including easy read versions) – GM developed for locality communication	Ali Jones / Anna Perkins
Update (add date):	<p><b>March 2022:</b></p> <p><b>PCNs:</b> Cancer Leads identified in 62 of the 67 PCNs. Cancer Support Workers appointed in 9 PCNs to support the ‘personalised care for cancer’ programme</p> <p><b>Screening:</b> Session held 25/1/2022 between PCN leads, Answer Cancer &amp; Section 7a team to provide support to PCNs to improve uptake of 3 screening programmes – link PCNs with the support from Answer Cancer and CSILs (Screening Improvement Leads)</p> <p><b>Patient facing communications:</b> Range of material in different format/media and different languages to support public/patient presentation and attendance</p> <p><b>Homelessness &amp; Health:</b> Initial meeting took place 12/1/22 – agreement to work together to share existing information from GM Live webinars with healthcare teams, to share the ‘cancer symptom recognition’ materials with non-healthcare teams and to arrange a call between the clinical leads for the 2 programmes of work to identify and progress other joint working opportunities – potentially a Gateway C webinar specifically for teams supporting homeless people in GM</p> <p><b>RDCs:</b> On target to deliver RDC pathways in GM by 31/3/2021. Ongoing work through RDC Programme Board and localities to ensure equality of access</p> <p><b>Lower GI / FIT</b> – programme of work in place which includes patient facing communications messages in different languages (and easy-read) – to be designed and delivered before 31/3/2022 and shared with localities for distribution.</p>		

**GM Cancer Alliance – Projects and Governance (data / diagnostics / treatment)**

Project/Work area	Aim	Objective/Output	Owner & Timeframe
National Cancer Programme Inequalities in Cancer Care	To link with the national 'Reducing Inequalities in Cancer Care' to gather examples of best practice from other Alliances and to scope opportunities to implement approaches in Greater Manchester	Robust GM plan in line with national Cancer Alliance opportunities and priorities	Ali Jones / Dave Shackley, GM Cancer
Pathway Boards	To ensure all pathway boards have an identified project / priority relating to addressing inequalities in their pathway	Via Clinical Lead Appraisal and Pathway Board work plan process, agree a priority for each of the pathway boards	Alison Armstrong, GM Cancer
Backlog Recovery	Ensure the recovery of the backlog of cancer diagnostics and treatments addresses the issue of inequalities and that patients are not disadvantaged by the approach taken	Equitable access to cancer diagnostics and treatment in addressing the backlog of cancer patients in the GM system	Lisa Galligan-Dawson
Equality Impact Assessments	The Alliance will review and refresh their approach to the completion of EIAs and will ensure <b>all</b> GM Cancer Alliance projects complete an EIA and that this forms part of the on-going Alliance governance and reporting process	Redesign EIA process for GM Cancer Set process for GM Cancer for review and approval of EIAs Ensure alignment of GM Cancer projects with the GM approach to EIAs	Ali Jones / Alison Armstrong
Data	Access to cancer system data and reporting on a regular basis	Develop GM SitRep to include equity data and report on a monthly basis to GM Cells – link	Phil Graham, GM Cancer

		to the equity data packs and provide the drill-down facilities to explore referral and treatment data with respect to inequalities	
Personalised Care	Development of a programme of work to support the Personalised Care project which identifies and addresses inequalities		Ben Heyworth, The Christie NHS FT
<b>Update (add date):</b>	<p><b>March 2022:</b></p> <p><b>EIA:</b> Work underway to ensure the GM Cancer EIA document and process aligns with the agreed GM model</p> <p><b>Personalised Care:</b> Action plan to be expanded to include details of the inequalities work initiated as part of this project</p> <p><b>Pathway Boards:</b> Annual Pathway Board work programmes to be finalised mid-March which will include a project / priority relating to addressing inequalities for each pathway. This will be shared with the board once agreed by the GM Cancer Senior Management Team</p>		

<b>Single Queue Diagnostics and Consolidation of Oncology Outpatient Provision</b>			
<b>Project/Work area</b>	<b>Aim</b>	<b>Objective/Output</b>	<b>Owner &amp; Timeframe</b>
Geographical equality of access	GM Cancer to support the system to implement single queues for diagnostics to ensure equality of access <b>ensuring appropriate EIAs undertaken</b> where service changes are involved	Equity of waiting time across GM	Lisa Galligan-Dawson

**Update (add date):**

**March 2022:** SQD update paper produced to summarise outputs from the pilot projects and outline recommendations.

DRAFT

Workforce			
Project/Work area	Aim	Objective/Output	Owner & Timeframe
Cancer workforce	Improve diversity in all cancer roles – including senior roles – across all organisations	<p>Develop a workforce inequalities task &amp; finish group.</p> <p>Small cohort of cancer workforce representatives undergoing the Regional Race Equality Change Agents Programme (RECAP) to conduct an organisation change project to influence race workforce equality. Project leads to feed into task &amp; finish group.</p>	<p>Suzanne Lilley, GM Cancer</p> <p>Jess Docksey, GM Cancer</p>
Cancer Workforce	Enhance NHS Care Services in Greater Manchester through Equality, diversity and inclusion	<p>An integrated and widely accessible educational resource for GM clinical teams that both:</p> <ul style="list-style-type: none"> <li>• Addresses service-specific equality, diversity and inclusion issues to reduce health inequalities</li> <li>• Nurtures talent from less represented staff groups</li> </ul>	Ben Heyworth, The Christie
Research workforce	Build a research workforce more accurately reflecting the diversity of our geographies (Manchester & Global), adequately trained in EDI through partner organisations	To be completed by ICS	Greater Manchester Health & Social Care Partnership
<b>Update (add date):</b>	<b>March 2022:</b>		

	<p>The <b>workforce inequalities group</b> is established and met for the first time on 18/1/2022. Group consensus is to focus on workforce race equality in the first instance until March 2023, and then to review the focus in relation to other protected characteristics. Action plan to be developed.</p> <p><b>Enhance NHS Care Services</b> in Greater Manchester through Equality, diversity and inclusion' – recruitment of dedicated project and education managers around April 2022 to initiate this work.</p>
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GM System Engagement: CCGs / Localities			
Project/Work area	Aim	Objective/Output	Owner & Timeframe
Locality Inclusion	Work with GM Directors of Commissioning in the first instance to engage locality inclusion groups to identify and address variation in relation to cancer referrals, treatment and outcomes	Locality approach to the analysis and use of data on cancer inclusion and inequalities	Ian Mello, Bury CCG, Director of Commissioning
CCG Data - Tableau	CCG / locality use of data on cancer referrals and first treatments – CADEAS data	CCGs using and acting upon data to identify address variation in referral and first treatment by pathway / PCN / patient group	Alison Jones, GM Cancer working with all CCGs' Cancer Commissioning Managers
<b>Update (add date):</b>	<p><b>March 2022:</b> Ongoing use of CADEAS data and access for localities to inform locality work on cancer service recovery. Engagement with Elective Recovery &amp; Reform work on inequalities.</p> <p>Locality Inclusion – On 22<sup>nd</sup> Feb 2022 – NHS Bury CCG facilitated a Cancer Inequalities Workshop. The workshop was led by Ian Mello (Director of Secondary Care Commissioning) and Dr Liane Harris Macmillan GP and had representatives from Local Authority, Primary/Secondary Care, Public Health and the third sector. The outcome of the workshop is through a T&amp;F group to drill down into the identified data areas and produce a single integrated whole system Cancer Inequalities Action Plan for Bury.</p>		

<b>Title of paper:</b>	Solutions to stabilise Greater Manchester Breast Services and improve performance against national cancer waiting time standards.
<b>Purpose of the paper:</b>	To provide GM Cancer Board with an overview of the proposed solutions and next steps in the development of the implementation plan.
<b>Summary outline of main points / highlights / issues:</b>	<p>PFB enabled a Task and Finish group to develop short to medium term solutions to support the stabilisation of breast services across GM. The GM Cancer Pathway Board facilitated clinically led workshops to develop the proposed solutions which cover these three areas of priority:</p> <ul style="list-style-type: none"> <li>• Improving the quality and appropriateness of referrals to secondary care</li> <li>• Developing an alternative pathway for mastalgia (breast pain)</li> <li>• Expediting breast radiology workforce expansion</li> </ul>
<b>Consulted:</b>	<p>GM Cancer Breast Pathway Board          GM Cancer Breast Clinical Leads          GM Chief Operating Officers          GM Executive Medical Directors          GM Provider Federation Board – 11<sup>th</sup> February 2022</p>
<b>Author of paper and contact details:</b>	<p><b>Name:</b> Ms Clare Garnsey  <b>Title:</b> Consultant Oncoplastic Breast Surgeon, Bolton NHS Foundation Trust and Clinical Lead for Breast, GM Cancer</p> <p><b>Name:</b> Claire O'Rourke  <b>Title:</b> Managing Director, GM Cancer</p> <p><b>Name:</b> Claire Goldrick  <b>Title:</b> Pathway Manager, GM Cancer  <b>Email:</b> <a href="mailto:Claire.goldrick@nhs.net">Claire.goldrick@nhs.net</a></p>



<b>Title:</b>	Solutions to stabilise Greater Manchester Breast Services and improve performance against national cancer waiting time standards.
<b>Audience:</b>	Provider Federation Board
<b>Date:</b>	11 <sup>th</sup> February 2022
<b>Owner:</b>	Professor Jane Eddleston, Group Joint Medical Director MFT
<b>Author:</b>	Clare Garnsey, Consultant Oncoplastic Breast Surgeon, Bolton NHS Foundation Trust and Clinical Lead for Breast, GM Cancer Claire Goldrick, Pathway Manager, GM Cancer Claire O'Rourke, Managing Director, GM Cancer

### **Executive Summary:**

A paper was submitted to PFB on 20<sup>th</sup> October 2021 detailing the capacity and workforce issues of the Greater Manchester, East and Mid-Cheshire breast services.

In response, PFB requested that a Breast Services Task and Finish Group, led by Professor Jane Eddleston (Group Joint Medical Director MFT and GM Gold Clinical Lead), develop solutions to stabilise breast services and improve performance against national cancer waiting time standards.

There are three key concepts from which the proposed recommendations have been developed:

- Optimise primary care engagement with the regional primary care breast education programme to improve the quality and appropriateness of referrals to secondary care. Managing breast symptoms, that are not suspicious for breast cancer, in primary care will be necessary to recover the 2WW 'referral to first appointment' national target.
- Development and implementation of a Greater Manchester mastalgia (breast pain) pathway. 20% of all 2WW breast referrals to secondary care are for patients with mastalgia which, without red flag symptoms, is not a symptom of breast cancer. Changes to national guidance during COVID-19 have permitted the development of alternative, more suitable pathways for these patients, and could safely support the redirection of 18% of 2WW referrals. Regional implementation of this novel mastalgia pathway would allow for a potential saving of £933,512 per annum which would remain within the breast diagnostic pathway to recover the 2WW cancer target. The proposal for a new, equitable mastalgia pathway for GM has been ratified by clinical colleagues and is expected to take 24 months to implement across all providers.

- Recommendations to support the longer-term stabilisation and growth of the breast radiology workforce, including training and capital investment, are detailed in this paper. Providing physical space to train and job-planned capacity for training both the non-medical and medical radiology workforce will be essential. To deliver a meaningful expansion in the breast radiology workforce, breast services will require significant support and capital investment to better engage with the work of the National Breast Imaging Academy and, in time, the North West Imaging Academy.

**Key actions for consideration (see section 4):**

- To support and encourage high levels of primary care engagement with the regional breast education programme, improving the quality and appropriateness of referrals to secondary care whilst protecting pathways that lead to earlier diagnosis of breast cancer.
- To approve the proposed implementation plan for the mastalgia (breast pain) pathway, safely redirecting up to 18% of 2WW non-urgent breast referrals.
- Approve the recommendations for breast radiology workforce development, ensuring growth of this fragile specialty is not further delayed during the COVID recovery period.
- Consider regional funding options for the breast recovery plan, ensuring equitable recovery around the region and capitalising on potential time and financial savings from accepting one regional recovery model.

## **Introduction to Breast Cancer services in Greater Manchester**

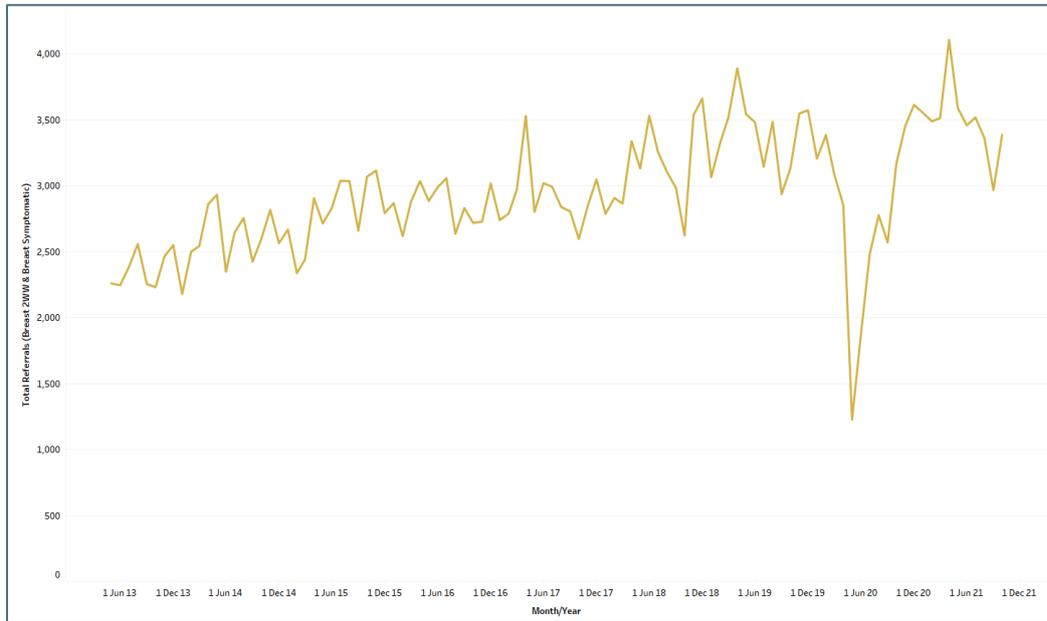
Breast Cancer services account for a significant proportion of the cancer workflow across Greater Manchester and East Cheshire:

- There are seven breast cancer units across six providers in Greater Manchester: Bolton, East Cheshire, Manchester (Wythenshawe), Mid Cheshire, North Manchester (now part of MFT), Tameside and Glossop, and Wigan.
- Of those, three services host a national breast screening programme: Bolton, Manchester, and Wigan.
- Breast cancer urgent referrals account for between 16-18% of all suspected cancer referrals, second only to lower gastrointestinal (see appendix 1).
- In contrast to other specialties, 'non-urgent' breast referrals (where the GP does not suspect cancer) must also be seen within two weeks of referral. Because of this, 25% of 2WW referrals in Greater Manchester are breast referrals.
- Breast cancer accounts for approximately 16% of all cancer incidence (calculated from figures given for February 2020-November 2021).
- The approximate conversion rate for suspected cancer referrals is 6.7% (calculated using median referral numbers from April 2017 to October 2021 across GM and East Cheshire and incidence data from 2017-2021 (excluding 2019 as data unavailable)). The conversion rate for 'non-urgent' 2WW referrals is approximately 1-1.5%.

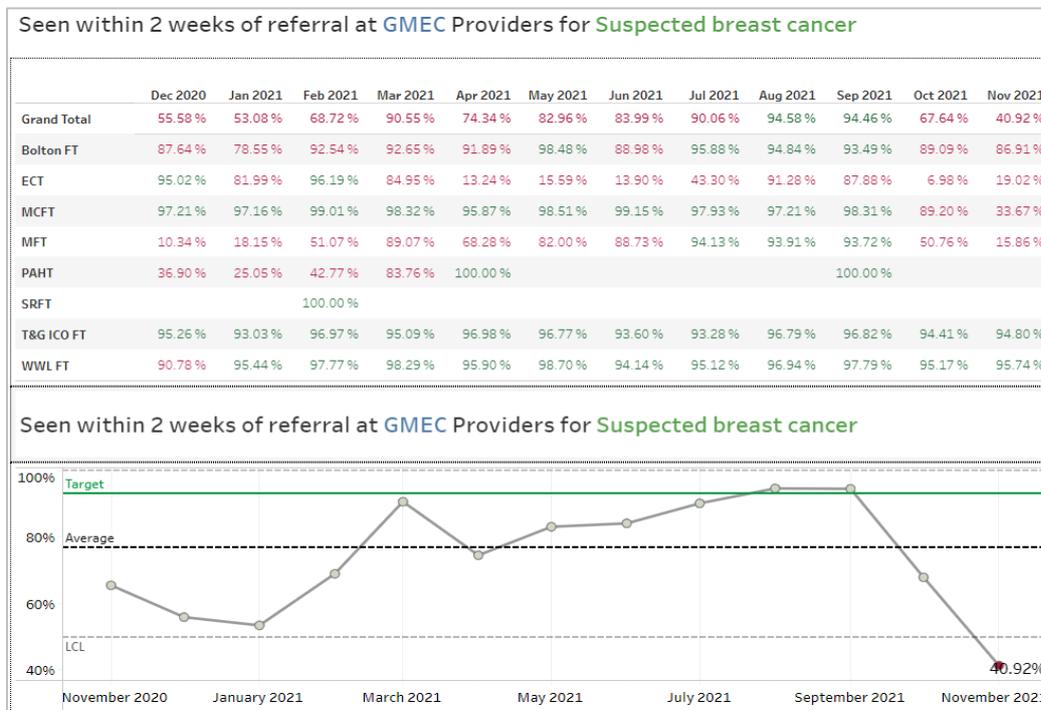
Resilience in breast cancer services has deteriorated over the past ten years. The unplanned closure of two breast units (Salford and Stockport) in 2016 and 2019 was due to radiology workforce shortages and added unsustainable pressure on the remaining services and workforce. Increasing referrals (see figure 1), without a corresponding increase in investment, are impacting the ability to meet the national cancer waiting time standards across Greater Manchester and East and Mid-Cheshire (see figure 2 and 3). This problem has been further exacerbated by the COVID-19 pandemic due to workforce pressures, fluctuations in referral numbers, reduced access to theatre, together with an initial suspension of the NHS Breast Screening Programme (and the resultant backlog), followed by a significant reduction in screening clinic capacity (due to social distancing).

The recovery of the national screening programme has significantly impacted the capacity of the three screening units within GM to deliver their 2WW waiting time target. As of November 2021, approximately 25,837 women remained in the tier 4 and 5 (people invited but not screened and people delayed an invitation respectively) breast screening backlog. The NHS priorities and operational planning guidance documents indicate the national target to restore all breast screening services by March 2022. Breast screening recovery plans predict that this target will not be met in Manchester.

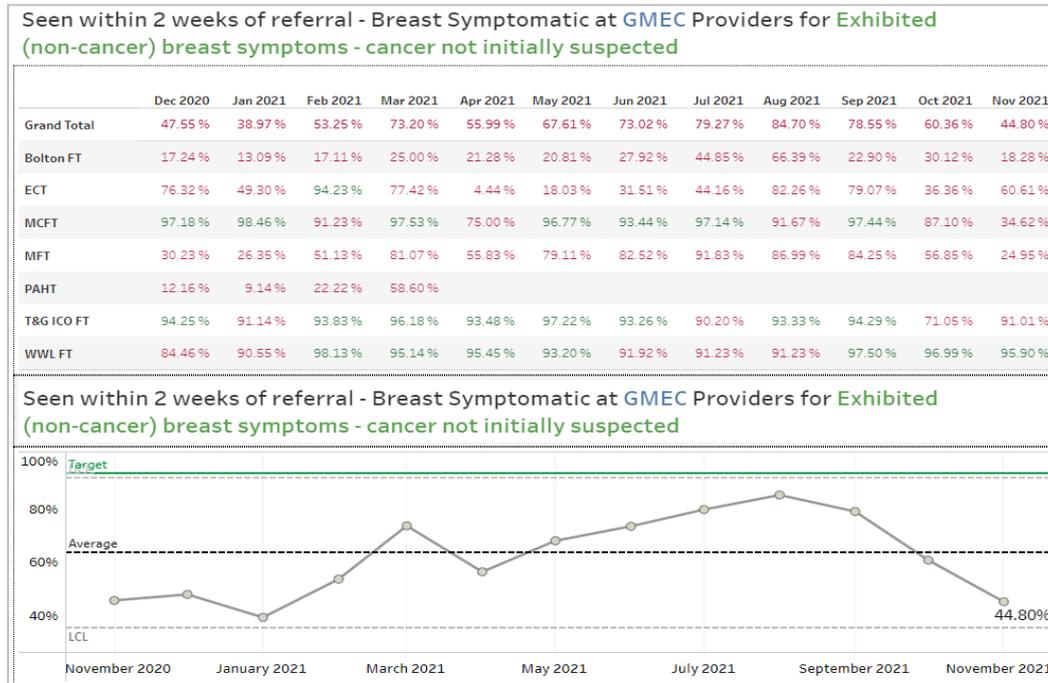
**Figure 1:** Graph demonstrates the continual increase of referrals for breast 2WW referrals (cancer suspected and cancer not suspected combined) across GM from June 2013 – December 2021.



**Figure 2:** Percentage of patients meeting national cancer waiting time standard of 'first seen within two weeks of referral' for suspected breast cancer from December 2020 – November 2021.



**Figure 3:** Percentage of patients meeting national cancer waiting time standard of ‘first seen within two weeks of referral’ for symptoms not suspicious for breast cancer from December 2020–November 2021.



Although figures 2 and 3 demonstrate that 2WW performance has been poor throughout the COVID-19 pandemic, there were issues with services’ ability to meet national targets prior to the pandemic (see appendix 2).

Furthermore, some services that appear to be meeting the national 2WW standard are doing so by offering a first appointment which does not provide triple diagnostic assessment (examination, imaging and biopsy) in a single visit (one-stop clinic). This is contrary to the NICE 2016 quality standards for breast cancer care and results in an extended patient pathway with inefficient use of the workforce.

The Breast Services Task and Finish Group held two workshops in December 2021 to develop the solutions proposed in this paper. The workshops were attended by clinical leaders from the multidisciplinary teams of all seven breast services, together with representatives from PFB, GM Cancer, the National Breast Imaging Academy, and the North West Imaging Academy.

The proposed solution is described in 3 sections:

1. Improving the quality and appropriateness of referrals to secondary care
2. Developing an alternative pathway for mastalgia (breast pain)
3. Expediting breast radiology workforce expansion.

## **Section 1: Improving the quality and appropriateness of referrals to secondary care**

The GM Cancer Breast Pathway Board has developed a primary care education programme. The aim is to enhance primary care colleagues' breast care knowledge, increase early cancer diagnosis and improve the quality and appropriateness of referrals to secondary care. Currently, 20% of referrals to secondary care for breast are for mastalgia (breast pain) and approximately 5% are for physiological nipple discharge, neither of which are symptoms of breast cancer. The regional primary care education package will support primary care clinicians to manage a proportion of this population of patients without referral to secondary care.

Due to the COVID-19 pandemic, GM Manchester Breast Pathway Board has developed a digital education offer for primary care to continue engagement, despite the suspension of face-to-face education events. The digital education programme includes:

- An interactive webinar series for primary care which has been scheduled from December 2021 to March 2022, covering eight localities within GM and Cheshire. The webinar includes a live introduction and interactive Q&A session with a local clinical lead and six short, pre-recorded presentations on screening, breast lump assessment, mastalgia, nipple discharge, gynaecomastia, and secondary breast cancer.
  - Feedback from the first education webinar was extremely positive. 100% of attendees would recommend the session to colleagues and all attendees said they would be likely/highly likely to change their practice following the webinar.
  - The presentations were pre-recorded so they can be further utilised on the GM Cancer website, GatewayC and for future educational events in 2022/23.
- The GM Cancer Breast Clinical Lead and the GM Cancer GP Lead hosted a GatewayC live webinar on symptoms of breast cancer which remains available on the GatewayC website to view on demand.
- The pathway board has developed management algorithms to aid primary care decision-making for patients presenting with mastalgia and nipple discharge. These algorithms have been uploaded to the Electronic Referral System so they can be reviewed prior to the GP making a secondary care referral.

East Cheshire NHS Trust hosts GP trainees within their breast unit for short training placements. This interaction with breast clinicians and breast care nurses is invaluable as breast-specific GP training is otherwise extremely limited. It is recommended that this education programme is adopted across GM to support the relationship between primary and secondary care.

The pathway board have met with Sarah Taylor (GP Cancer Early Diagnosis Lead for Greater Manchester, GM Cancer, CRUK, GatewayC GP Lead) and Alison Jones (Commissioning Director, GM Cancer) to discuss the suitability of Advice and Guidance for Breast. There were reservations over the utility of the system when all patients referred must be seen within two weeks of referral for both suspected cancer and symptomatic referrals. It was decided that



current focus should remain on providing education options for primary care colleagues and promoting the use of primary care management algorithms. Advice and Guidance for breast can be reviewed again once more tumour groups have implemented the offer.

**Recommendations for consideration by PFB:**

- Support and encourage high levels of primary care engagement with the regional breast education programme, to improve the quality and appropriateness of referrals to secondary care whilst protecting pathways that lead to earlier diagnosis of breast cancer.
- Approve the regional adoption of GP trainee breast placements and support the GM Cancer Breast Pathway Board to implement the programme throughout Greater Manchester, East and Mid Cheshire.

## **Section 2: Developing an alternative pathway for mastalgia (breast pain)**

### **2.1 Mastalgia referrals to secondary care**

- A regional multicentre audit shows that approximately 20% of all breast referrals to secondary care are for mastalgia without any symptoms suggestive of breast cancer.
- Mastalgia is very common and will occur in 70% of women during their lifetime. It is a normal, physiological process of the dynamic breast tissue or a non-breast symptom, such as costochondritis of the underlying chest wall. Mastalgia alone is not a symptom of breast cancer.
- Women with mastalgia are currently being referred to a 2WW secondary care triple assessment clinic (clinical examination, imaging, and biopsy) They are undergoing unnecessary examination and diagnostic tests, causing unnecessary patient anxiety.
- If patients could be safely assessed and satisfactorily reassured outside the resource-intensive, one-stop triple assessment clinic, this would release clinic capacity to help recover the national cancer waiting time performance for patients with symptoms suggestive of an underlying malignancy.

### **2.2 Evidence to support the lack of association between mastalgia and breast cancer**

Gandhi et al (Manchester University Foundation Trust) have recently published a prospective cohort study of 10,830 consecutive patients referred from primary care, of which, 1972 (18%) were referred with mastalgia and no other red flag symptoms. Mammography was performed in 1,112 women with mastalgia, identifying 8 cancers (0.7%). In this population of 1,972 women with mastalgia, breast cancer incidence was 0.4%. This compared to ~5% in the 82% of patients referred to clinic with non-mastalgia symptoms and 1% in the NHS Breast Screening Programme of asymptomatic women. This study suggests there is no association between mastalgia and breast cancer.

### **2.3 National Guidance and development of alternative mastalgia pathways during the pandemic**

At the start of the COVID-19 pandemic in England, the Association of Breast Surgery published a statement on 15<sup>th</sup> March 2020, suggesting that telephone consultations should be considered for women presenting with mastalgia without symptoms suggestive of breast cancer.

In April 2020, the Greater Manchester Cancer Breast Pathway Board accepted the Association of Breast Surgery advice and recommended that breast services consider alternative mastalgia pathways that could vary from the standard triple assessment.

NHS England published guidance in January 2021, advising that patients at very low risk of breast cancer, including those with mastalgia, could be given digital information and educational resource around breast health as an alternative to triple assessment clinic with or without direct-to-test imaging.

The Breast Surgery GIRFT Programme National Speciality Report of February 2021 states that people with a lower risk of breast cancer need to be assessed and reassured but they do not need to experience the stress of an urgent suspected cancer pathway, recommending that alternative mechanisms for managing lower risk referrals need to be urgently explored.

Manchester University Foundation Trust and Bolton NHS Foundation Trust have independently developed alternative mastalgia pathways which both offer the following:

- Nurse-led telephone clinic within 14 days of referral
- Consultation with standard breast cancer risk assessment (includes family history)
- Verbal and written patient information about mastalgia
- Safety-netting by providing patient information on the signs and symptoms of breast cancer
- Direct-to-test mammogram for patients over 40 years of age.

An audit at Manchester University Foundation Trust of 692 patients attending the mastalgia telephone clinic showed:

- 78% of patients avoided triple assessment clinic
- 49% were referred for direct-to-test mammogram
- 0.4% incidence of malignancy on mammogram which were incidental findings (50% contralateral breast to symptoms)
- 98% of patients surveyed would recommend the pathway.

Snapshot audit of 98 patients in Bolton NHS Foundation Trust showed:

- 73% of patients avoided triple assessment clinic
- 72% were referred for direct-to-test mammogram
- 1 patient had incidental finding of pre-cancer at a site distant to symptoms.

Mid-Nottinghamshire have developed an alternative mastalgia pathway which offers the following:

- Nurse-led face-to-face clinic in a community setting, outside of secondary care
- Medical history and examination
- Extended family history assessment using a new family history assessment tool and software system
- Verbal and written patient information about mastalgia
- Safety-netting by providing patient information on the signs and symptoms of breast cancer.

Development of these alternative mastalgia pathways progressed without national or regional coordination, leaving providers with a number of pathways to consider for long term (post-pandemic) implementation.

#### 2.4 Greater Manchester, East and Mid Cheshire preferred mastalgia pathway

At a workshop held on 25<sup>th</sup> June 2021, the GM Cancer Breast Pathway Board considered the Mid-Nottinghamshire mastalgia pathway and raised the following concerns:

- Specialist breast care nurses and advanced nurse practitioners felt that the additional family history assessment could add a level of anxiety for women and contradict the evidence-based messaging that mastalgia is not a symptom of breast cancer.
- Conducting a standard family history as per NICE guidance CG164 was considered appropriate, with referral to a secondary care dedicated family history clinic as required.
- An important aspect of the Mid-Nottinghamshire pathway is that it is conducted in a community setting. Identifying primary care/community facilities to conduct these clinics from, and staff with sufficient skills who could attend these facilities, was considered a significant barrier to implementation in Greater Manchester, East and Mid Cheshire.
- It was acknowledged that breast clinical examination lacks specificity and sensitivity. Breast clinical examination, in the setting of a patient with mastalgia and no other symptoms, was considered to add little value and may lead to over-investigation, unnecessary patient anxiety and false reassurance.

On 1<sup>st</sup> December 2021, breast services' clinical leads from all providers, specialist breast nurses, radiologists, senior GM Cancer representatives and PFB representatives participated in a workshop, chaired by Professor Jane Eddleston (MFT Group Joint Medical Director and Chair of the Breast PFB Task and Finish Group) and Miss Clare Garnsey (GM Cancer Breast Clinical Lead) to discuss management of mastalgia.

- The group was unanimous in their support of a unified, equitable pathway across GM for patients with mastalgia.
- The group agreed that delivering a nurse led or GPER (General Practitioner with Extended Role) led telephone service is sufficient in providing reassurance to patients with mastalgia which has been evidenced by the teams across GM.
- The group agreed that current evidence suggests that there is no association between mastalgia and breast cancer, and the cancer detection rate (0.4%) in the imaged mastalgia population is less than the cancer detection rate in the asymptomatic breast screening population (1%). The regional expert group concluded that it is highly likely that mammograms should not be offered to women with mastalgia, although, it was acknowledged that further published evidence is needed before the region could support de-escalation of mammogram provision for women over 40.
- It was agreed that telephone mastalgia clinics should be developed in all regional breast services.
- Initially women presenting with mastalgia over 40 years of age will be offered a mammogram. There will be a multicentre prospective audit to determine whether the low incidence of breast cancer in this group, as demonstrated by the South Manchester

audit, can be replicated by other providers in the region, despite different staffing pressures and different patient demographics e.g. age, socioeconomic deprivation, lack of English language etc.

## 2.5 Resource

Clinical leads from across GM have agreed that a Breast Specialist Nurse (0.4WTE) would be required to support the implementation of the mastalgia pathway across GM and East Cheshire for 24 months. The role would include:

- Championing the new mastalgia pathway and supporting all breast services in Greater Manchester, East and Mid-Cheshire to implement the service.
- Training colleagues to deliver the nurse-led or GPER-led telephone clinic service.
- Development of standardised GP and patient information to support the telephone clinic service.
- Coordinate data collection of regional audit:
  - Patient satisfaction questionnaires
  - Cancer incidence audit which may support the de-escalation of mammogram use.

To further support implementation, four GPs with Extended Roles (GPER) would be recruited to deliver the services in localities that do not have current advanced nurse practitioners or GPERs already in post. It is recommended that these positions are funded centrally for 12 months to expedite the implementation of the pathway and prevent intraregional inequity. It would be expected that trusts would use the 12 months to develop a business case to add the GPER salary into their revenue expenditure.

## 2.6 Impact of alternative mastalgia pathway:

- Implementation of a more appropriate pathway for women with mastalgia, avoiding the anxiety associated with an unnecessary 2WW referral to secondary care.
- Reduction in unnecessary investigations for patients resulting from unnecessary clinical examination, which has a low specificity.
- Reduced radiation exposure by avoiding over 6000 unnecessary mammograms per annum.
- Release of workforce capacity in breast services.
- Reduced demand on the resource intensive triple assessment clinics which will support breast services to recover the national cancer waiting time standard of 14 days from referral to first assessment.
- For most providers, the workforce savings from redirecting these patients out of the workforce-dense, costly triple assessment clinics will enable the telephone-led service to be set-up at a cost-saving.

**Figure 4:** Mastalgia Pathway implementation: Resource impact calculation

	<b>Total</b>
Total number of breast referrals per annum in GM (symptomatic and suspected cancer referrals)	34,784*
Total expected number of mastalgia referrals (20% of total referrals)	6957
Total number of referrals suitable for mastalgia telephone clinic after clinical triage (18% of total referrals. Triage excludes those with dementia, learning difficulties, language issues, complexity (breast implants etc.))	6261
Number of triple assessment clinics saved (10 patients per clinic)	626
Total cost of triple assessment clinics for all breast referrals (2019/20 National Breast Surgery Out-Patient tariff £1844.20 – 10 patients per clinic**)	£6,414,865
Total cost of potentially avoidable triple assessment clinics (18%)	£1,154,469
Project costs:	
1x 0.4WTE B8a Specialist Nurse (£60,196 per annum) for 24 months	£48,156.80
4x 0.4WTE GPER*** for 12 months	£172,800
Total potential saving per annum for next 24 months	£933,512.20

\*Data calculated using the median number of annual referrals across Greater Manchester and East Cheshire from Apr18-Oct21 (32,160). Implementation is expected to take 24 months to implement, therefore 4% annual increase in referrals has been added to illustrate potential cost savings.

\*\*Out-patient tariff not including diagnostic test costs e.g. mammography/biopsy.

\*\*\*GPwER salary based on 90k salary plus 20% on-costs.

## 2.7 Recommendations for consideration by PFB:

- Approval of the proposed mastalgia pathway, enabling women with mastalgia to be managed outside the resource-intensive triple assessment clinic and hence supporting recovery of the 2WW national cancer waiting time standard.
- Consider regional funding options for a 0.4WTE Band 8a lead nurse and four 0.4WTE GPER to ensure equitable and timely implementation around the region.
- Support the GM Cancer Breast Pathway Board's leadership in implementing the mastalgia pathway rather than forming additional regional breast boards during a time of workforce challenges.

## **Section 3: Expediting Breast Radiology Workforce Expansion**

### **3.1 Radiology Workforce Overview**

The Royal College of Radiologists Clinical Radiology UK Workforce Census 2020 reported significant challenges within the breast radiologist workforce:

- There is a national shortage of breast radiologists, and despite increasing demand, breast radiologist numbers show minimal growth (1% per year, compared with 4% radiology average).
- Breast radiology has more vacancies than any other area of the radiology workforce.
- 24% of breast radiologists are due to retire in the next five years.

All seven breast services in Greater Manchester, East and Mid Cheshire are impacted by this national shortage:

- All providers are regularly failing to provide a one-stop triple assessment diagnostic clinic appointment within the national cancer waiting time standard target for patients with new symptoms suggestive of breast cancer.
- There are delays in the NHS Breast Screening Programme COVID recovery plans, particularly within our Manchester Breast Screening Programme.
- Patients with a previous history of breast cancer, on Patient Initiated Follow-Up (PIFU) pathways, are facing significant delays waiting for diagnostic tests when reporting new symptoms that may indicate breast cancer recurrence.
- There is low morale within our radiologist workforce with a high prevalence of work-related injury, unreasonable work rates and an inability to take annual leave (see results of the Greater Manchester Breast Radiologist Workforce Survey appendix 3).

We are unable to train consultant radiologists quickly enough to tackle the current breast radiology workforce crisis nor meet increasing demand on services. It is imperative that alternative solutions are developed, particularly non-medical workforce expansion and breaking the current cycle in which colleagues are not given the time or physical space to train, exacerbating the workforce crisis further.

On 8<sup>th</sup> December 2021, breast radiology clinical leads from all providers, Dr Mary Wilson (Lead for the National Breast Imaging Academy (NBIA)), North West Imaging Academy (NWIA) representatives, senior GM Cancer representatives and PFB representatives participated in a workshop, chaired by Professor Jane Eddleston and Miss Clare Garnsey to discuss steps that could be taken to expedite the growth of the non-medical radiology workforce. These proposals were then discussed with North West NHS Breast Screening Programme leaders on 20<sup>th</sup> December 2021. The following proposal was agreed as a sensible, realistic, and progressive way forward, by all attendees of both meetings:

- Mandating of proven, gold-standard, efficient one-stop (triple assessment) diagnostic pathways to make the best use radiology workforce time.

- Improve clinical engagement with, and promote close collaboration between, the National Breast Imaging Academy (NBIA) and North West Imaging Academy (NWIA).
- Expanding the role of breast radiology advanced practitioners.
- Capital funding to provide the physical space required to train colleagues.
- Engaging with potential future solutions e.g. AI.

### 3.2 Mandating of gold-standard, one-stop pathways

In 2002, NICE published *Improving Outcomes in Breast Cancer* which recommended that triple assessment (clinical examination, imaging, and biopsy) should be available to patients with new breast symptoms in a single visit.

The 2016 NICE quality standard for breast cancer made triple assessment in a one-stop clinic a standard, rather than a recommendation, stating that, *'People with suspected breast cancer referred to specialist services are (to be) offered the triple diagnostic assessment in a single hospital visit'*.

Providing patients with one-stop diagnostic clinics supports the rapid diagnosis of breast cancer (or the exclusion of cancer) whilst reducing the anxiety and stress associated with multiple visits. In addition, this is the most efficient pathway for our over-stretched radiology workforce and is strongly supported by clinicians around the region.

Despite this clear guidance, and strong clinical support, some services in the region do not provide triple assessment in a one-stop clinic. Such providers may appear to be meeting the 2WW waiting time target (as the patient is first seen within 14 days) but the diagnostic pathway is not complete in that first visit. This is a sub-standard, longer pathway for the patient and inefficient use of the workforce.

Radiology Recommendation 1: All breast services should take immediate action to provide one-stop triple assessment clinics for patients with breast symptoms in line with national guidance.

### 3.3 Working with the National Breast Imaging Academy (NBIA) and North West Imaging Academy (NWIA)

The National Breast Imaging Academy (NIBA) is a national initiative funded by Health Education England and hosted by Manchester University Foundation Trust. It is the national centre of excellence for breast imaging training, providing high-quality training programmes via an online learning hub. Charitable funding is underway to build a physical training academy at the Wythenshawe site to increase training capacity.

### 3.3.1 Develop communication channels between the NBIA and NWIA

- National funding has recently been made available to pump-prime a North West Imaging Academy (NWIA).
- There are limited trainers available in Greater Manchester from which to form a breast imaging faculty for academy work. It is imperative that the NWIA and NBIA work collaboratively to best support breast imaging workforce training and expansion.
- The National Breast Imaging Academy is run by highly regarded breast imaging experts and a programme of training has already been developed. The NWIA should capitalise on these pre-developed training programmes and resources to expedite the North West breast specialty work programme.

Radiology Recommendation 2: The NWIA to liaise closely with the NBIA to best support the training and expansion of the North West breast imaging workforce.

### 3.3.2 Associate mammographers

- In addition to a national shortage of radiologists there is also a shortage of radiographers.
- The National Breast Imaging Academy provides a 12-month apprenticeship for non-healthcare professionals to qualify as associate mammographers.
- The apprenticeship levy covers training costs, but providers are required to fund a band 4 salary for the 12 months of training, despite the apprentice being unable to add to service provision until qualified.
- Funding the salary of the apprentices would expedite the growth of this area of the workforce which would, in turn, allow fully qualified mammographers to train as advanced practitioners and contribute to overall up-skilling of the workforce.

Radiology Recommendation 3: Regional funding of 7 associate mammographer salaries to cover their 12-month training period expediting the growth of this area of the radiology workforce.

### 3.3.3 Training mammographers to train associate mammographers

- Mammographers must be qualified in order to supervise the training of associate mammographers.
- Funding Practice Educator courses would expand the pool of mammographers able to train the apprentice associate mammographers, whilst supporting the professional development of mammographers.

Radiology Recommendation 4: Regional funding of 10 Practice Educator courses.

### 3.3.4 Supporting providers to host National Breast Imaging Academy Fellowships and Breast Clinician Trainees

- The NBIA also offers the following training programmes:

- 1-year Breast Radiology Fellowship which prepares senior radiology trainees for consultant radiologist posts and is popular with international doctors.
- 3-year Breast Clinician training programme for qualified doctors wishing to re-train in radiology.
- For both training programmes, half of the salary is paid by HEE, and half by the host trust.
- In 2020/2021 only one breast service in the North West of England was able to host a NBIA trainee due to a lack of experienced radiologist time to train and a lack of physical space to train in.
- To expand the senior radiology workforce, we must prioritise training and incentivise trainers.

Radiology Recommendation 5: Consider a regional standard for provision of NBIA training placements by each breast service in Greater Manchester.

Radiology Recommendation 6: Financial commitment by provider executive directors to support consultant radiologists with job planned and fully funded breast radiology training PAs (2 PAs per week per fellowship or trainee breast clinician).

Radiology Recommendation 7: Support retired/retiring radiologists/radiographers to retain a number of PAs specifically for training purposes.

Radiology Recommendation 8: Regional funding of five 12-month fellowships (HEE funds half the salary).

Radiology Recommendation 9: Regional funding of two 3-year Breast Clinician training programme positions (HEE funds half the salary)..

### 3.4 Expanding the role of advanced practitioners

- Advanced practitioners (including consultant radiographers) are band 7 and 8 radiographers who have gained the qualifications, knowledge and clinical skills to provide services that historically would have been provided by consultant radiologists e.g. mammogram film reading, image-guided biopsy, insertion of localisation seeds for impalpable cancer excision.
- Training of radiology advance practitioners in Greater Manchester has been very successful over the last 10 years, but there is intraregional variation in the breadth of advanced practitioners' scope of work and limits to funding for advanced practice training courses.
- Advanced practitioners should be encouraged to continue to expand their scope of work rather than completing just one or two aspects of advanced training.

Radiology Recommendation 10: Regional funding of 10 additional advanced practice courses to expedite the upskilling of this area of the radiology workforce.

### 3.5 Capital funding to provide the physical space required to train colleagues

- A number of breast services in the region are working from physical spaces that are not fit for purpose with little investment for many decades.

- Newer purpose-built units, such as the Nightingale Centre in South Manchester, can no longer manage demand due to the unplanned closure of Salford and Stockport breast services in the last 5 years resulting in the transfer of patient care.
- With huge pressure on services to recover the national cancer targets and the NHS Breast Screening Programme KPIs, services do not have the physical space to permit a trainee to slowly work through a case on USS or mammogram equipment.

Radiology Recommendation 11: Capital funding of equipment and physical space solution to enable training opportunities to be fully realised.

### 3.6 Engaging with potential future solutions e.g. Artificial Intelligence (AI)

- A study published in *Nature* in Jan 2020 showed [AI and human] mammogram reading to be non-inferior to [human and human] mammogram reading but other studies have not replicated this finding.
- Independent prospective testing against national benchmarks is needed.

Radiology Recommendation 12: AI technology is not a solution for now, but Greater Manchester breast services should be strongly encouraged to participate in studies investigating the use of AI technology.

### 3.7 Cost of proposed radiology workforce expansion for 2022/2023

Following engagement with radiology clinical leads across Greater Manchester, East and Mid Cheshire, the numbers of courses and trainees needed to support the development of the workforce over the next 24 months have been described below.

**Figure 5:** Cost of proposed radiology workforce expansion 2022/23

	Salary for 12-month training position (£)	Length of course in years	WTE	Cost per course (£)	Number of courses	Total cost (£)
Band 4 associate mammographer	30,674	1	7	N/A	N/A	214,718
Practice Educator Course	N/A	NA	N/A	700	10	7,000
Advanced Practice Course	N/A	NA	N/A	3,500	10	35,000
Radiology Fellowship (Half of salary funded by HEE and half by host trust)	30,000	1	5	N/A	N/A	150,000

Breast Clinician (Half of salary funded by HEE and half by host trust)	30,000	3	2	N/A	N/A	180,000
<b>TOTAL COST</b>						<b>£586,718.00</b>

### 3.8 Cost of required capital investment in estate and equipment

To support maximal radiology workforce expansion through regional training, as well as increasing service capacity and housing a growing workforce, breast services estates require a full review and significant investment.

Funding for new purpose-built breast units at providers with older estates (including Bolton and Wigan), expedition of the planned breast build at the North Manchester site and funding of the National Breast Imaging Academy build at the South Manchester site is required.

In the short term, some less radical measures can be taken to improve access to breast radiology training whilst also adding capacity to the system.

**Figure 6:** Capital Investment in estate and equipment

Resource requirement	Cost (£)	Number required	Total cost (£)
Provision of additional mammogram (+/- tomosynthesis) at sites lacking imaging capacity (Cost variation due to varying estate refurbishment costs required to house a new mammogram machine)	170,000 – 250,000	5	850,000-1,250,000
Provision of additional ultrasound suites at sites lacking physical imaging capacity (Cost variation due to varying estate refurbishment costs required to house a new USS machine)	80,000-120,000	4	320,000-480,000
Supporting the North Manchester and Oldham service to move onto a single site whilst awaiting their new hospital build which is estimated to complete ~2027	Not calculated	1	Not calculated
Support the build of an extension at South Manchester to house the National Breast Imaging Academy until the full £7,000,000 academy build can be completed	3,200,000	1	2,200,000 (1,000,000 funding already in place)

### **3.9 Summary of radiology recommendations for consideration by PFB:**

These solutions will improve the breast radiology workforce position in the next 12-24 months.

1. All breast services should take immediate action to provide one-stop triple assessment clinics for patients with breast symptoms in line with national guidance.
2. The NWIA to liaise closely with the NBIA to best support the training and expansion of the North West breast imaging workforce.
3. Regional funding of 7 associate mammographer salaries to cover their 12-month training period expediting the growth of this area of the radiology workforce.
4. Regional funding of 10 Practice Educator courses.
5. Consider a regional standard for provision of NBIA training placements by each breast service in Greater Manchester.
6. Financial commitment by provider executive directors to support consultant radiologists with job planned and fully funded breast radiology training PAs (2 PAs per week per fellowship or trainee breast clinician).
7. Support retired/retiring radiologists/radiographers to retain a number of PAs specifically for training purposes.
8. Regional funding of five 12-month fellowships (HEE funds half the salary).
9. Regional funding of two 3-year Breast Clinician training programme positions (HEE funds half the salary)..
10. Regional funding of 10 additional advanced practice courses to expedite the upskilling of this area of the radiology workforce.
11. Capital funding of equipment and physical space solutions to enable training opportunities to be fully realised.
12. AI technology is not a solution for now, but Greater Manchester breast services should be strongly encouraged to participate in studies investigating the use of AI technology.

#### **Section 4: Summary of recommendations for consideration and approval by PFB:**

##### Safely reducing inappropriate referrals to secondary care

- Support and encourage high levels of primary care engagement with the regional breast education programme, to reduce unnecessary referrals to secondary care whilst protecting pathways that lead to earlier diagnosis of breast cancer.
- Approve the regional adoption of GP trainee breast placements and support the GM Cancer Breast Pathway Board to implement the programme throughout Greater Manchester, East and Mid Cheshire.

##### Developing an alternative pathway for mastalgia (breast pain)

- Approval of the proposed mastalgia pathway, enabling women with mastalgia to be managed outside the resource-intensive triple assessment clinic and hence supporting recovery of the 2WW national cancer waiting time standard.
- Consider regional funding options for a 0.4WTE Band 8 lead nurse and four 0.4WTE GPER to ensure equitable and timely implementation around the region.
- Support the GM Cancer Breast Pathway Board's leadership in implementing the mastalgia pathway rather than forming additional regional breast boards during a time of workforce challenges.

**Project costs for 24 months: £220,956.80** (see figure 4)

##### Expediting Breast Radiology Workforce Expansion

1. All breast services should take immediate action to provide one-stop triple assessment clinics for patients with breast symptoms in line with national guidance.
2. The NWIA to liaise closely with the NBIA to best support the training and expansion of the North West breast imaging workforce.
3. Regional funding of 7 associate mammographer salaries to cover their 12-month training period expediting the growth of this area of the radiology workforce.
4. Regional funding of 10 Practice Educator courses.
5. Consider a regional standard for provision of NBIA training placements by each breast service in Greater Manchester.
6. Financial commitment by provider executive directors to support consultant radiologists with job planned and fully funded breast radiology training PAs (2 PAs per week per fellowship or trainee breast clinician).
7. Support retired/retiring radiologists/radiographers to retain a number of PAs specifically for training purposes.
8. Regional funding of five 12-month fellowships (HEE funds half the salary).
9. Regional funding of two 3-year Breast Clinician training programme positions.
10. Regional funding of 10 additional advanced practice courses to expedite the up skilling of this area of the radiology workforce.



11. Capital funding of equipment and physical space solution to enable training opportunities to be fully realised.
12. AI technology is not a solution for now, but Greater Manchester breast services should be strongly encouraged to participate in studies investigating the use of AI technology.

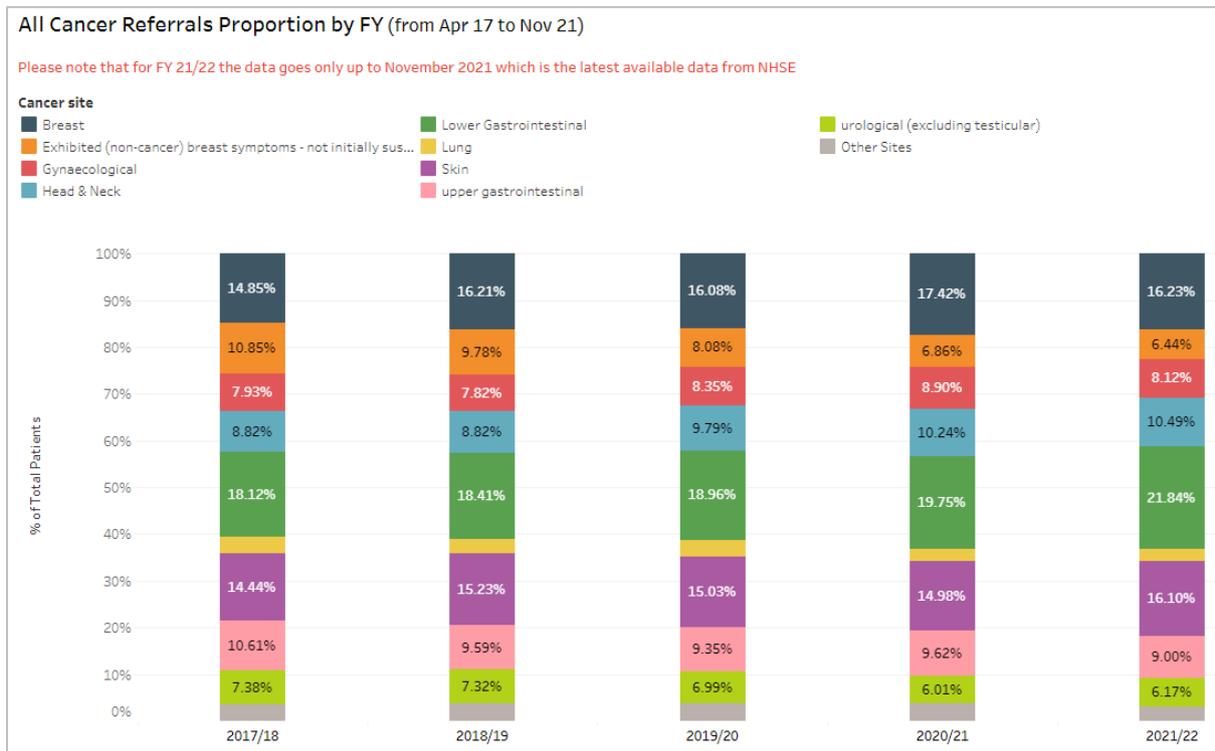
**Radiology workforce training costs for 2022/23: £586,718.00** (see figure 5)

**Capital Investment** (see figure 6)

Appendix

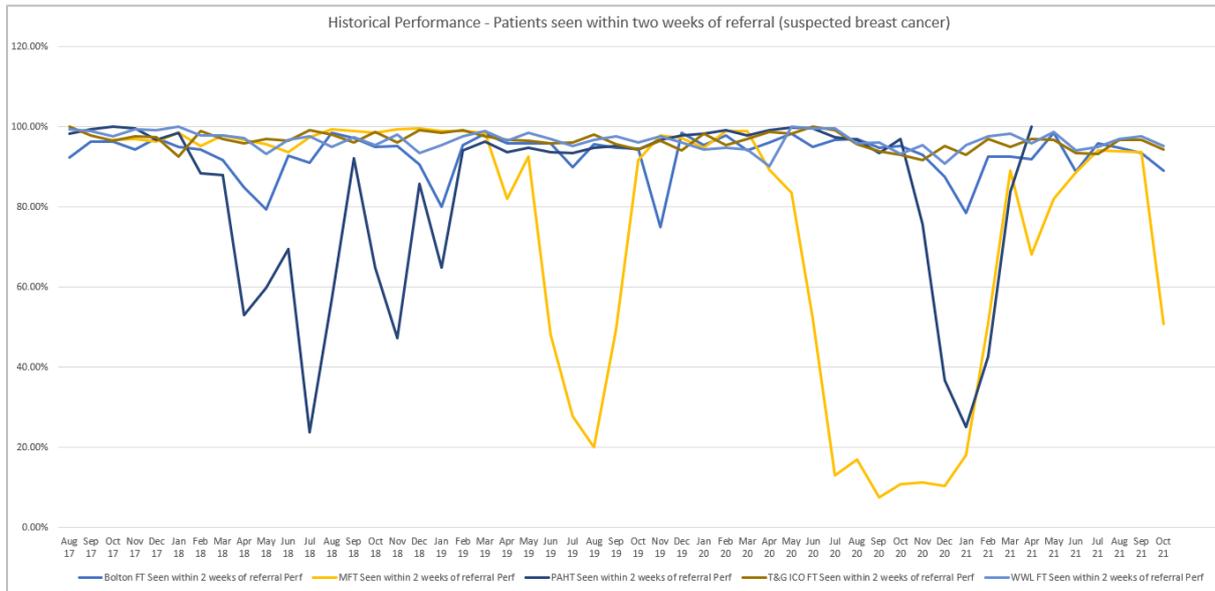
Appendix 1: Suspected Cancer Referrals in Greater Manchester

Graph of all cancer referrals by cancer site indicates that Breast accounts for the second largest number of referrals second only to Lower GI. However, in addition, all breast referrals where cancer is not suspected must also be seen within two weeks of referral, making Breast the single biggest source of cancer referrals.

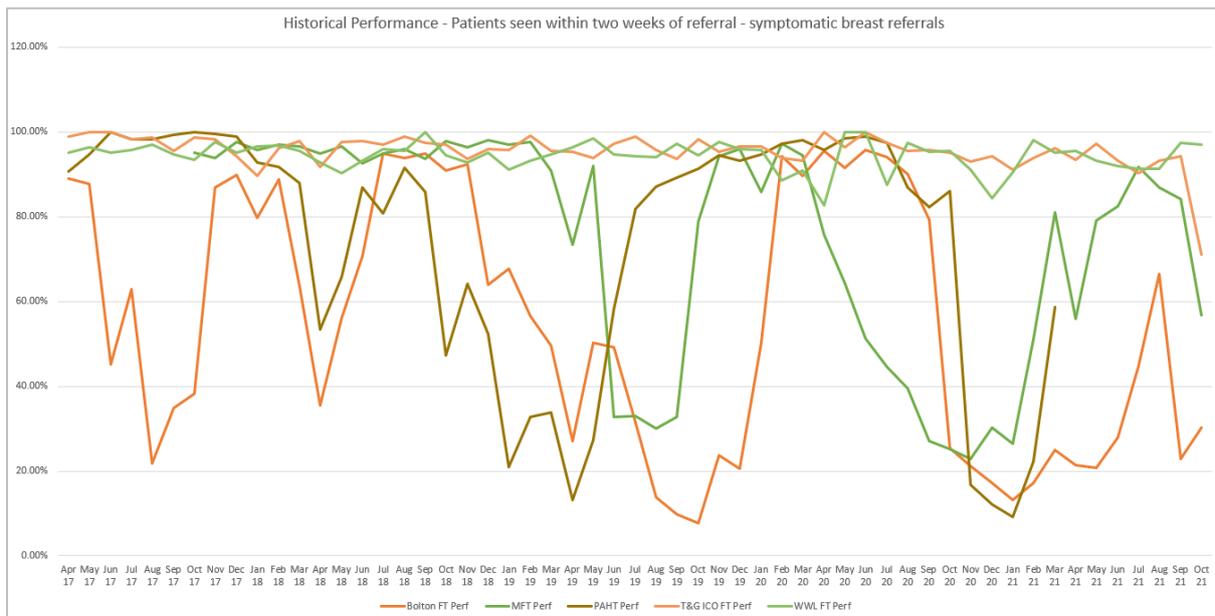


Appendix 2: Performance

Historical performance figures showing percentage of patients seen within two weeks of referral for suspected breast cancer from April 2017- October 2021



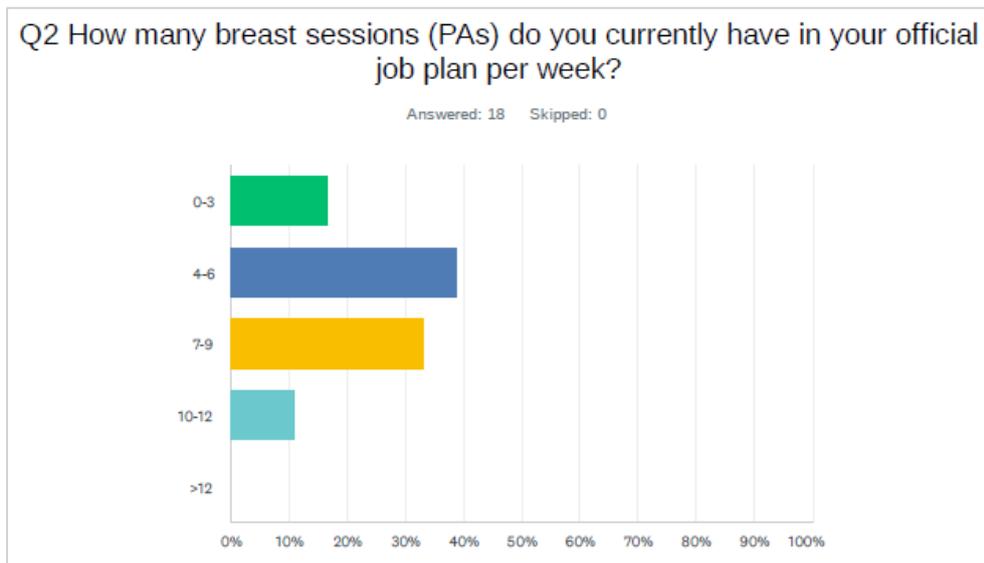
Historical performance figures showing percentage of patients seen within two weeks of symptomatic breast referrals from April 2017- October 2021



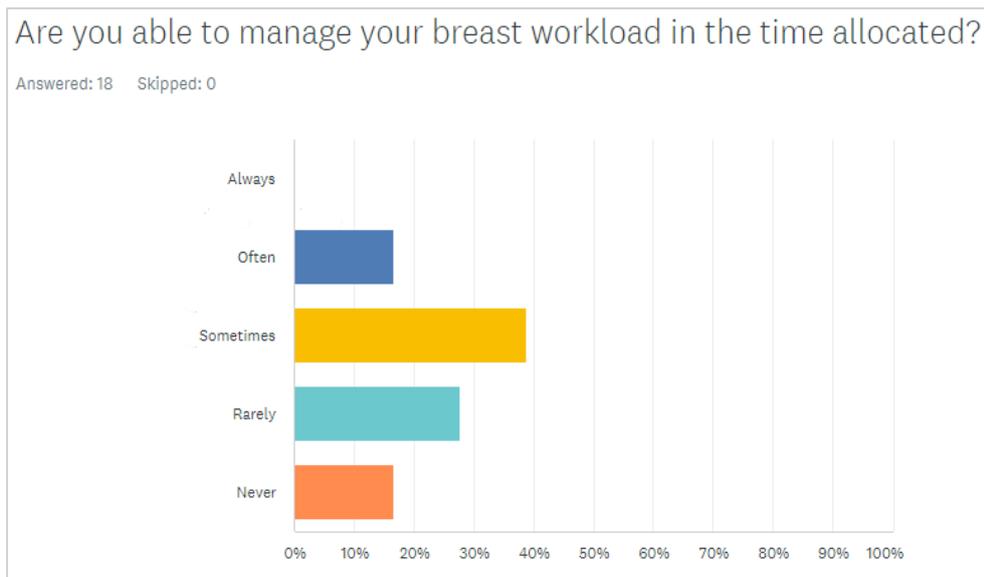
Appendix 3: Radiology Workforce Survey

A survey was sent to all breast consultant radiologists in GM via Trust Breast Clinical Leads (18 responses in total, approx. 40 potential recipients)

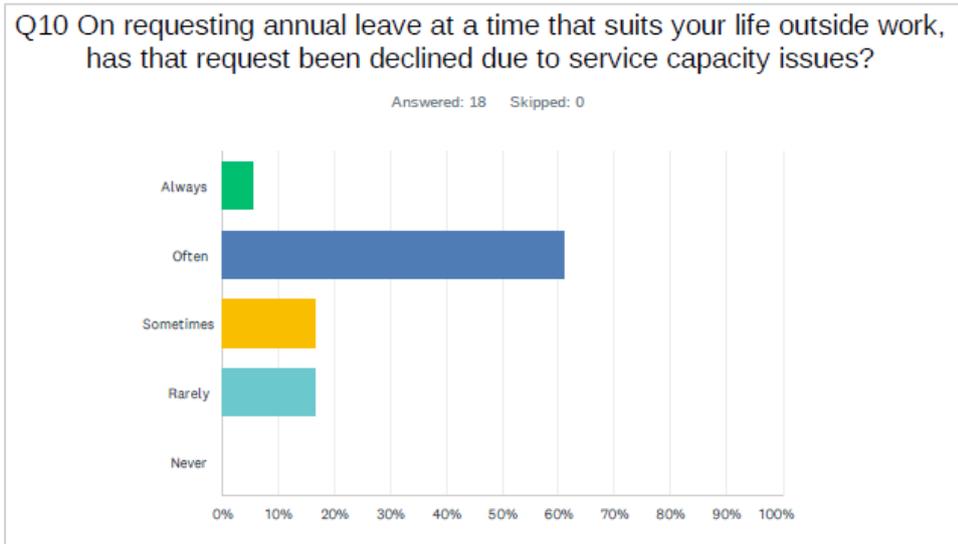
The majority of those that answered had between 4 – 9 job-planned breast sessions per week.



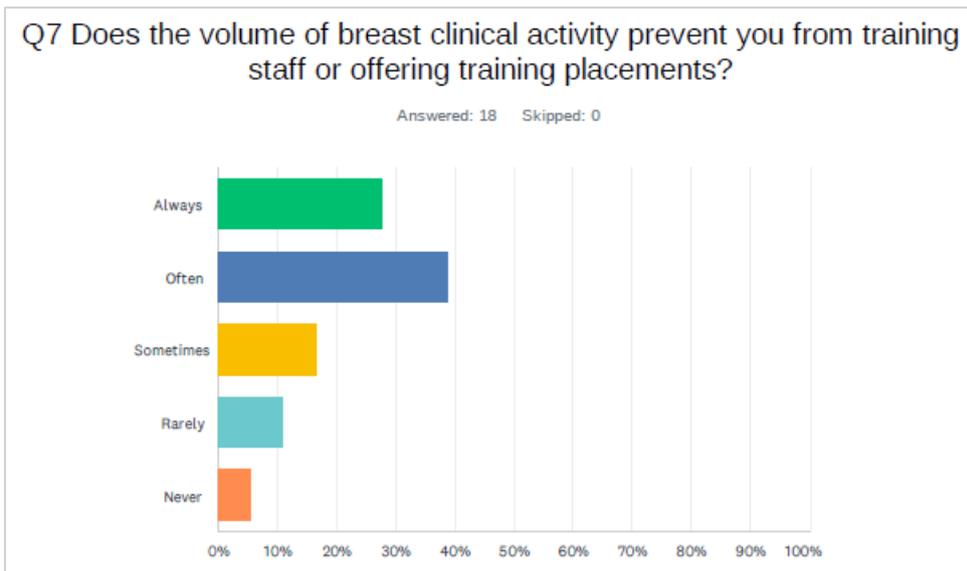
66% said there is too much or far too much breast work in ratio to non-breast work and 44% said they are rarely/never able to manage their workload in the time allocated.



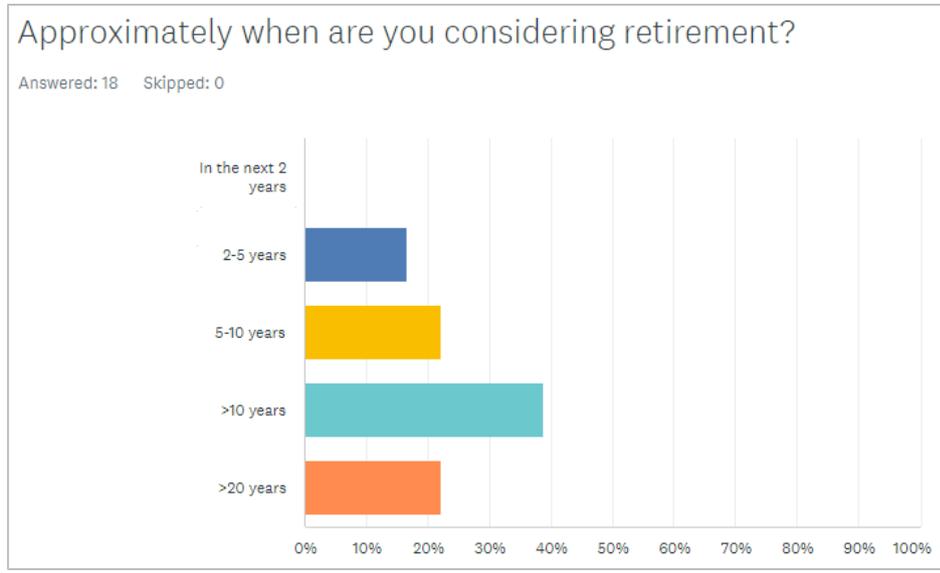
61% said that their requests for annual leave are often declined due to service capacity issues and 72.22% said that when they do take annual leave, their colleagues cover their workload in addition to their own job plans.



83.34% said that the of breast clinical activity prevents them from training staff or offering training placements and participating in research activities, such as trial participation.



Almost 40% of the current workforce are considering retirement within the next 10 years.



## Cancer Board 28 March 2022

<b>Title of paper:</b>	Lung Cancer Performance Review  Incorporates: Action plan, 2019-2020 National Lung Cancer Audit results & National Lung Cancer GIRFT Report
<b>Purpose of the paper:</b>	To advise the Board of the performance and position in lung cancer based on the results of the National Lung Cancer Audit 2019-2021 (2022 NLCA Report) and the recommendations in the 2022 National Lung cancer GIRFT report , along with progress on pathway recommendations previously made to the GM Cancer Board.  This paper additionally outlines the approach to recovery in Lung Cancer, including areas for specific investment.
<b>Summary outline of main points / highlights / issues</b>	<ul style="list-style-type: none"> <li>• Proposed approach to the recovery of Lung Cancer following the impact of the Covid-19 pandemic</li> <li>• Comprehensive Action Plan to deliver improvement in all aspects of lung cancer in accordance with findings in the NLCA and GIRFT reports</li> <li>• Update on current improvement initiatives</li> <li>• To seek approval from the GM Cancer Board on actions to address the findings of this performance review</li> </ul>
<b>Consulted</b>	<ul style="list-style-type: none"> <li>• GM Lung Cancer Pathway Board, March 23<sup>rd</sup> 2022</li> <li>• MFT Lung Cancer &amp; Thoracic Surgery Directorate senior leadership team</li> <li>• The Christie Lung Oncology Clinical Director</li> <li>• GM Prehab4cancer clinical lead &amp; programme manager</li> </ul>
<b>Author of paper and contact details</b>	<p><b>Name:</b> Dr Matthew Evison  <b>Title:</b> Lung Cancer Pathway Director, GM Cancer  <b>Email:</b> <a href="mailto:m.evison@nhs.net">m.evison@nhs.net</a></p> <p><b>Name:</b> Lisa Galligan-Dawson  <b>Title:</b> Performance Director, GM Cancer  <b>Email:</b> <a href="mailto:lisa.galligan-dawson@nhs.net">lisa.galligan-dawson@nhs.net</a></p>

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## 1. Executive Summary & Action Plan

### Executive Summary

This paper provides a comprehensive overview of lung cancer performance in Greater Manchester (GM), incorporating results of the National Lung Cancer Audit 2019-2021 (2022 NLCA Report) and the 2022 National Lung cancer Getting It Right First Time (GIRFT) report. In addition, this report aims to provide an update on the improvement initiatives previously presented at the GM Cancer Board; namely Single Queue Pilot in EBUS, One-stop Lung Cancer Clinic, PET Booking Pilot and Consolidation of Oncology Appointments. Finally, this paper outlines the approach to recovery in Lung Cancer, including areas for specific investment.

#### National Lung Cancer Audit (NLCA)

The National Lung Cancer Audit (NLCA) is a programme of work that aims to improve the quality of care, services and clinical outcomes for patients with lung cancer in England. 2022 NLCA annual report provides information on the process of care and outcomes for patients diagnosed with lung cancer between 1 January 2019 and 31 December 2020 in. A new process is in place this year, in response to the covid-19 pandemic. The key areas within the report are:

- GM appears to have a worse performance status distribution compared to the national aggregate data. In particular, in 2019 GM had the highest proportion of PS2 patients and in 2020 GM has the highest proportion of PS2 and PS3 patients
- GM appears to have a significantly higher proportion of patients with lung cancer diagnosed as stage I versus the national aggregate data. (4-5% above the national level of 20%, despite the covid -19 pandemic). The combined proportion of patients diagnosed with stage I and II lung cancer in GM in 2019 and 2020 was 34% and 32% respectively compared to 28% and 27% nationally.
- GM has significantly higher active smoking rates in patients diagnosed with lung cancer compared with the England average: 2019 26% vs 21% and 2020 23% vs 18%.

- >90% of patients diagnosed with lung cancer should be seen by a lung CNS. In GM, the performance against this standard was 88% and 83% in 2019 and 2020. The reduction in 2020 may reflect the redeployment of CNS teams during the covid-19 pandemic. GM was higher than the national aggregate data at 80% and 75% respectively.
- The impact of covid-19 on the pathological diagnosis of lung cancer in GM had been significant with a 13% reduction in performance
- In 2020 the proportion of patients PS0-2 with stage I/II NSCLC being treated with surgery is 16% lower than the level across England. In contrast to this, GM has significantly higher overall proportion of lung cancer patients having curative-intent radiotherapy compared to the national level and this figure is above the upper quartile range in both 2019 and 2020. Furthermore, in 2020, during the covid-19 pandemic, GM has the highest proportion of NSCLC PS 0-2 patients undergoing curative-intent radiotherapy at 43%, which is 17% higher than the level across England.
- Despite the increasing proportion receiving curative-intent radiotherapy, there is an actual reduction in the numbers of treatments with curative intent. These actual numbers lay bare the impact of covid-19 as there were 96 less PS 0-2 stage I/II NSCLC patients in 2020 compared to 2019 and 142 less curative-intent treatments given in this category
- In GM the active treatment rates in stage IIIA NSCLC are higher than the England average and the rates of chemoradiotherapy are also higher than the England average. However, 50% (26/52) of all patients with stage IIIA PS 0-2 NSCLC that underwent surgery in 2019 did not undergo chemotherapy as well and in 2020 this figure was 56%
- The rate of systemic anti-cancer therapy (SACT) in advanced stage NSCLC is lower than the average across England and a long way below the national target of 65% set by the NLCA and the 70% set by the national lung cancer GIRFT report,
- The median overall survival in lung cancer across the ten CCGs in 2019 ranged from 176 days at the lowest and 407 days at the maximum – the highest survival rate in GM is over double that of the lowest survival rate.
- Covid-19 has affected every performance metric in lung cancer. It has affected surgical resection rates greater than any other areas with a 15% reduction in the proportion of patients with NSCLC PS 0-2 stage I/II undergoing surgery
- A high proportion of patients with stage IIIA NSCLC that undergo surgery do not undergo adjuvant chemotherapy (approximately 50-55%)

- Systemic anti-cancer therapy rates in advanced stage NSCLC PS 0-1 are below national rates and significantly below the NLCA target of 65% and the GIRFT recommendation of 70% (GM 50% and 48% in 2019/2020).
- Low rates of systemic anti-cancer therapy had also been seen in small cell lung cancer with GM below the NLCA and GIRFT target of 70% (GM 61% and 66% in 2019/2020). Furthermore, the proportion of patients with small cell lung cancer that commence treatment is 20% and 14% in 2019/2020 respectively – significantly below the GIRFT recommendation of 80%
- Survival outcomes in GM suggest significant variation and inequity of access to optimal care

The full report is available on page 16

#### National Lung Cancer Getting It Right First Time (GIRFT)

GIRFT is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. In the latest review, there are 33 recommendations for local, regional and national prioritisation, focusing particularly on the following aspects of lung cancer care which offer the most significant opportunities for improvements in outcome.

- Making a rapid and precise diagnosis
- Delivering effective treatment
- Effective multidisciplinary working
- Improving data and information
- Resources, organisation and accountability.

Significant progress has been made with many of the recommendations, but there remains pivotal work in 22 areas:

- Respiratory teams to immediately move to providing proactive management of unexpected abnormal chest radiology and work with radiology departments to implement

pathways that deliver a three working day turnaround from abnormal chest X-ray or referral to CT scan report

- Key diagnostic investigations should be completed within 21 calendar days of the start of the pathway by adopting best practice recommendations on service configuration and pathway planning.
- Renegotiate the national PET-CT contract to include a five calendar day turnaround from request to report and available imaging for initial investigations of new diagnoses of lung cancer.
- An image-guided biopsy service should be available for all patients 52 weeks of the year, with appointments for the procedure being available (notwithstanding issues such as anti-coagulation or anti-platelet therapy) within five working days of the request.
- EBUS for lung cancer should be available within five calendar days of request and must comply with the national service specifications, with regular monitoring of performance by local commissioners
- Ensure a diagnostic and therapeutic ambulatory pleural service is available for all lung cancer patients, accessible within five working days, 52 weeks of the year.
- Pathological services should provide a maximum ten calendar day turnaround time for molecular profiling according to the national test directory of lung cancers to meet the requirements of the NOLCP.
- All trusts should have an overall radical treatment rate of 85% or more in those patients with NSCLC stages I-II and of performance status 0-2. This includes all treatment modalities (surgery, radiotherapy including SABR, multimodality treatment and thermoablative techniques).
- All trusts should have an overall surgical resection rate for NSCLC of over 20%.
- Trusts should monitor rates of post-surgical adjuvant and neoadjuvant treatments and this data should be available for national benchmarking
- Trusts should record and monitor multimodality treatment in stage IIIA disease and offer radical intent treatment as standard in fit patients
- All trusts should improve their treatment rates with SACT to achieve greater than 70% treatment for fit patients with advanced NSCLC, and greater than 70% chemotherapy rates in SCLC.

- Ensure that all patients with lung cancer have access to enhanced supportive care and/or specialist palliative care. Inpatient specialist palliative care provision should be available seven days per week.
- Produce and implement protocols for follow-up pathways following radical therapies.
- Review operational arrangements for multidisciplinary working to ensure it is as timely, efficient, and effective as possible and meeting the needs of patients.
- Improve timeliness and effectiveness of communication from the MDT to lung cancer patients and primary care.
- Monitor and performance manage trusts according to the key time points within the National Optimal Lung Cancer Pathway.
- Collect, analyse and publish an agreed EBUS dataset aligned to agreed performance metrics and standards.
- Improve the annual review of data within lung cancer services.
- Develop more relevant and generalisable methods of collecting data on patient-reported experience and outcomes.
- Roll out national implementation of risk-based CT screening for lung cancer.
- National bodies and local lung cancer services should continue to respond to the challenges presented by the COVID-19

### GM Data

The value of data in determining targeted actions and interventions, and monitoring associated improvement cannot be underestimated. Disaggregated, patient level 'live' data has been produced in GM on the Tableau System. This 'live' data confirms GM does not comply with the 62 days pathway target of 85% nor the 49 day national optimal lung cancer pathway. This supports GM ambitions to focus on single queue specialist cancer diagnostics system to improve efficiency in the cancer pathway. It also suggests the low systemic anti-cancer therapy levels in GM are unlikely due to pathway delays from the decision to treat and supports the approach to investigate the pathway prior to a decision to treat (audit of reflex testing and predictive marker testing) and the optimisation of patients through an expansion to the prehab4cancer pathway.

GM performance 2021 (01/01/2021 – 31/12/2021)

	<b>Two week wait referrals n=687</b>	<b>Consultant upgrade n=1551</b>
Referral to first MDT – median	26 days	15 days
Referral to first MDT – compliance with 21 day standard	37%	66%
Referral to first treatment – median	55 days	44 days
Referral to first treatment - compliance with 49 day standard	41%	56%
Referral to first treatment - compliance with 62 day standard	63%	71%
DTT to surgery – median	18 days	20 days
DTT to surgery – compliance with 21 day standard	67%	56%
DTT to radiotherapy – median	16 days	19 days
DTT to radiotherapy – compliance with 16 day standard	50%	39%
DTT to SACT – median	8 days	7 days
DTT to SACT – compliance with 14 day standard	84%	78%

Approach to Recovery

The findings from the National lung Cancer Audit, the GIRFT report, the National Cancer Waiting Times standards and GM’s own disaggregated data point to clear areas for targeted improvement. There are a number of existing operational groups that can take ownership of specific action delivery, but it is recommended that an oversight **‘Accelerated Lung Improvement Group’** should be formulated. The group will link to the GM Lung Cancer Pathway Board and report into the GM Cancer Recovery Board. This approach provides oversight of work streams spanning the entirety of the Lung Cancer pathway, and aligns with the ‘Cancer Operating Model’ of the new ICS.

When considering improvement, it should be recognised that there is already a commitment to roll out targeted lung health checks across Greater Manchester to drive improvements in early-stage lung cancer detection & a reduction in mortality. The GM Lung Health Check Working Group is currently developing a proposal for a collaborative multi-Trust Diagnostic & Treatment Centre. In addition to delivering screening, it has the potential to assist in the rapid GM recovery post-COVID by providing greater capacity, coordination, service development & delivery and workforce expansion in line with the requirements of the GM action plans. The successes of the single queue diagnostics programme can be replicated at scale embedding greater collaborative cross-Manchester working throughout all aspects of care, whilst also enabling a sustainable high quality 21<sup>st</sup> century service.

The proposed membership of this Accelerated Lung Improvement Group will be as follows:

<b>Matt Evison</b>	Chest Physician, Chair the Lung Pathway Board, GM Cancer
<b>Lisa Galligan-Dawson</b>	Performance Director, GM Cancer
<b>Seamus Grundy</b>	Chest Physician, Chair of the Lung Pathway Diagnostic Sub-group, GM Cancer
<b>David Woolf</b>	Clinical Oncologist, Chair of the Lung Treatment Sub-group, GM Cancer
<b>Felice Granato</b>	Thoracic Surgeon, Lead clinician for Thoracic Surgery, MFT
<b>Tom Thornber</b>	Director of Strategy, The Christie and Lead DOS for Cancer GM
<b>Rhidian Bramley</b>	Cancer Diagnostics Lead, GM Cancer
<b>Ali Jones</b>	Commissioning Director, GM Cancer, GM Early Diagnosis Lead
<b>Naseer Rehan</b>	Chest Physician, Fairfield Hospital, NCA

Overleaf is a summary of the current actions identified to ensure a rapid recovery from the covid-19 pandemic in lung cancer, to address areas of concern highlighted in the National Lung Cancer Audit report 2022 and to achieve the recommendations set out by the National Lung Cancer GIRFT report 2022.

Action	Owner	Target Timescale
<b>1. Making a rapid and precise diagnosis</b>		
Full implementation of the GM strategy for earlier diagnosis in symptomatic lung cancer ( <b>Appendix 1</b> )	Lung Improvement Group	January 2023
Deploy a GM digital platform for single queue booking and reporting for specialist lung cancer diagnostics to deliver PET, EBUS, CT Lung Biopsy & specialist pleural diagnostics within 5 days All procedures to be completed within 5 days of request (As per GM strategy for Delivering an accelerated diagnostic & staging lung cancer pathway in Greater Manchester - <b>Appendix 2</b> )	Lung Improvement Group	January 2024
Ensure all GM lung cancer physician teams have job planned time for daily triage and 'board round' of all patients on the lung cancer pathway (As per GM strategy for Delivering an accelerated diagnostic & staging lung cancer pathway in Greater Manchester - <b>Appendix 2</b> )	Lung Improvement Group	January 2023
Enhance the delivery of the tobacco dependency treatment in the GM lung cancer pathway: <ul style="list-style-type: none"> <li>Ad hoc on-the-day tobacco dependency treatment service to be developed and implemented at The Christie for lung cancer patients and medical oncology service at Wythenshawe</li> <li>All clinicians in GM lung cancer MDTs to complete either RCP Medical Management of Tobacco Dependency e-learning module or NCSCT training.</li> <li>GMMMGM tobacco dependency treatment protocol to implemented across lung cancer teams (<b>Appendix 3</b>)</li> </ul>	Lung Improvement Group	January 2023
<b>2. Delivering effective treatment</b>		
Launch and evaluate the GM One Stop Lung Cancer Clinic (KPIs are described in the One Stop Lung Cancer Clinic Overview – <b>Appendix 4</b> . This includes a KPI of clinic referral to decision to treat of ≤7 days in >75% of patients).	One-stop lung cancer clinic operational sub-group	November 2022
Expansion of a GM thermoablative service to optimise outcomes and provide equitable access	Lung Improvement Group	January 2023
Expansion of the Prehab4cancer programme to optimise outcomes and provide equitable access including: <ul style="list-style-type: none"> <li>GM spotlight audit on prehab4cancer referrals for eligible patients</li> <li>Integrate Prehab4cancer team into clinical service (One-stop lung cancer clinic)</li> <li>Modified prehab-rehab service for patients known to require adjuvant chemo post- surgery</li> <li>Explore expansion of prehab4cancer into advanced stage lung cancer</li> <li>Report outcomes of P4C in oncology patients</li> </ul>	Prehab4cancer Lung Sub-group	January 2023
Complete a GM wide audit of adherence to the GM Reflex Testing Protocol & audit turnaround times for predictive marker testing as part of this audit	Lung Pathway Board	July 2022

GM spotlight audit NSCLC stage I/II PS0-2 2021	Lung Pathway Board	July 2022
Development of a central tumour pathway	Lung Improvement	January 2023
Deep-dive audit into adjuvant chemotherapy following surgical resection	Wythenshawe Hospital, MFT	July 2022
Consider a change in terminology in stage III to sequential surgery-chemotherapy to move away from 'adjuvant' terminology that infers optional decision	Lung Pathway Board	July 2022
Implement a post-resection MDT at the regional thoracic surgery centre, one function of which is reviewing every patient eligible for adjuvant chemotherapy and optimising access to this	Lung Improvement Group	January 2023
Full implementation of the GM Lung Cancer Emergency Pathways protocols including the rapid referral of a new small cell lung cancer diagnosis via a dedicated proforma ( <b>Appendix 5</b> )	Lung Improvement Group & Lung Pathway Board	July 2022
Consider a WTE new small cell lung cancer GM co-ordinator to action a small cell diagnosis on day of diagnosis	Lung Improvement Group	January 2023
Ensure frailty assessment and comprehensive geriatric assessment via a specialist oncogeriatrician service is embedded within all GM medical oncology services	Lung Improvement Group	January 2023
<b>3. Effective multidisciplinary working</b>		
Complete and implement GM Lung MDT Reform project	Lung Pathway Board	July 2022
Incorporate a MDT annual review framework into the GM Lung MDT reform work for all sector MDTs to implement	Lung Pathway Board	July 2022
<b>4. Improving data and information</b>		
Complete & launch GM lung cancer pathway dashboard that includes the metrics of: 72hrs CXR/referral to CT, in addition to new live data of 21 days to MDT discussion and 49 days to commence treatment. Use this data system (GM Tableau) to monitor improvements in the pathway.	Lung Improvement Group	July 2022
Reduce unwarranted variation and improve inequality using real-time GM data monitoring and milestone wait data	Lung Improvement Group	January 2023
Deliver the 62-day cancer waiting time target by January 2023 (85% target)	Lung Improvement Group	January 2023
Deliver the 49-day day national optimal lung cancer pathway by January 2024 (85% target)	Lung Improvement Group	January 2024
Evaluation & publication of the impact of LNC-PATH on outcomes (LNC-PATH in operation since 2018)	Wythenshawe Hospital, MFT	July 2022
Complete and evaluate Safe-7 patient experience survey	Wythenshawe Hospital, MFT	July 2022
<b>5. Resources, organisation and accountability</b>		
Progress and accelerate a GM-wide roll out of the Lung Health Check Programme and approval of GM Diagnostic & Treatment Centre	GM Lung Health Check Group	January 2024

## Investment Opportunities

Two key areas have been identified for investment, to support compliance with the aforementioned reports.

### Increased Prehab4Cancer Services

The proposal is for the Prehab4Cancer team to integrate into the new one-stop lung cancer clinic. It would see the Prehab4Cancer and rehabilitation programme eligibility criteria be extended to include referrals for people diagnosed with advanced stage lung cancer disease (IIIB/IV). Approximately 500 patients per year. It would also include bespoke pathways for patients planned for surgery and then chemotherapy - providing early contact and support after surgery and supporting progression onto adjuvant chemotherapy (with increased tolerance to chemo regimes). The full proposal can be viewed on Page 38. There is a recurrent revenue funding requirement of **£243,836**.

### Post Resection MDT

The 2019/2020 NLCA data report identified that 50-55% patients in Greater Manchester with stage III NSCLC that underwent surgery did not proceed to complete their optimal treatment with adjuvant chemotherapy. Process and pathways are not in place to optimise the uptake of adjuvant chemotherapy after surgery or monitor adherence to adjuvant chemotherapy. To address these issues, the proposal is to with the launch a Post-Resection MDT and introduce the role of an 'Adjuvant chemotherapy patient navigator'. The full proposal can be viewed on Page 41. This initiative requires a recurrent revenue investment of **£71,400**.

It is proposed that funding for these initiatives should be generated from the Cancer Alliance budget for two years. An analysis into the effectiveness of the initiatives would take place, with a view of these being funded permanently if they generate the expected outcomes. Substantive recruitment to new posts is essential to attract the correct candidates. It is proposed that should the work programmes not progress beyond 24 months that these posts would be managed through natural turnover. The Board are asked to support this approach, with agreement, this would then be provided to PFB and DOF forum for approval.

### Further investment opportunities

Through the Lung Cancer Pathway Board and the Lung Improvement Group further proposals are in development and discussion including:

- A new small cell lung cancer (SCLC) pathway
  - A regional small cell lung cancer co-ordinator at The Christie Hospital to be contacted on the day of diagnosis of SCLC
  - A suspected small cell EBUS service at MRI where the use of Rapid On Site Evaluation (ROSE) can give a provisional diagnosis of small cell on the day of test and in an supported environment (additional CNS resource) patients are informed of the diagnosis and oncology review booked and confirmed through new SCLC co-ordinator
- A new central tumour pathway
  - This pathway will serve patients with a lung cancer that might be suitable for surgical resection but is at high risk of progression and unresectability unless an extra-ordinary rapid pathway is delivered. Pathway options are being worked up by the thoracic surgery team and may include a regional navigator and rapid access to diagnostic work-up within 7 days and inpatient surgical work-up moving straight to surgery.
- Investment proposal for an expanded oncogeriatric service for frailty assessment and management in lung cancer in GM
- Investment proposal for the expansion of a GM thermoablative service

### Existing Improvement Initiatives

#### Single Queue EBUS Pilot

In total 350 days were saved across the 219 patients involved in the pilot. Variation in participating services reduced by 42% and the waiting times by 21% despite limitations of the pilot. The patient experience survey identified the top priority for 75% of EBUS patients was to have the fastest possible EBUS regardless of travelling. 96% of EBUS patients surveyed in this pilot were 'Very Happy' or 'Happy' with the care they received.

The success of the pilot has led to a 'case for change' being produced to roll out the 'single queue' principle across EBUS and other appropriate services. (Appendix 6)

#### PET Booking Pilot

Direct telephone booking has been introduced in all but the central sector of GM as part of an improvement initiative to reduce delays in PET-CT, and allow for the co-ordinated

booking of staging diagnostics. Overall, an average of 2 pathways days were saved by introducing the direct booking service. As a result, in the immediate terms this is being expanded to include all areas of GM for Lung cancer, before wider roll out across other tumour sites. It is envisaged this service will be a core aspect of the single queue initiative, with digital booking in line with other specialist diagnostics.

### One-stop Lung Cancer Clinic

The GM One-stop Lung Cancer Clinic is an innovative regional service that provides a multi-disciplinary team to support patients with lung cancer suitable for curative-intent treatment but with different treatment options and considerations around co-morbidity and frailty. The clinic will ensure all GM patients will have access to high quality optimisation with prehab4cancer, frailty management, nutritional assessment, tobacco dependency treatment (CURE) and alcohol dependency treatment embedded within the clinic. It will provide patients with information and discussion with a surgeon, anaesthetist and oncologist to inform them of all aspects of different treatment options and then they will be supported by cancer nurse specialists and physicians to make treatment decisions. This clinic aims to deliver exceptional patient experience in a difficult shared decision making scenario and accelerated pathways through multi-modal interventions and consultations in a single visit to reach a decision (see Appendix 4). The first clinic will be held on 08 April 2022. Full evaluation will be completed, but an interim update will be provided after the first 3 months of operation.

### Oncology Outpatient Consolidation

This project is progressing, albeit delayed as an impact of the Omicron wave. Progress is being made with Bolton, and then MFT being the first two organisations to consolidate their oncology appointments. A trajectory for implementation is in place and it monitored through a fortnightly project meeting.

## Full Reports

### **1. The Greater Manchester Lung Health Check (LHC) Programme Overview**

Whilst this action is overseen by a dedicated GM LHC Board led, it is important to describe the vision and the opportunity for GM in delivering this large-scale programme as part of the wider Lung agenda and to bring full context to this paper. The opportunity is described below by Professor Richard Booton, Clinical Director for the Manchester Lung Health Check Programme.

The GM Cancer Alliance response to the NHSE Long Term Plan includes a commitment to roll out targeted lung health checks across Greater Manchester to drive improvements in early-stage lung cancer detection & a reduction in mortality. This represents a major challenge, to target ~750,000 eligible participants, and complete baseline screening by 2027. The infrastructure needed to successfully complete this programme will need to support 70,000 LDCT annually, 2,000 lung 2-week wait referrals & 1,300 new lung cancer diagnoses, ultimately leading to approximately 900 new lung cancer resections each year.

Even without the impact of COVID, this programme would have led to significant pressures on all aspects of the lung cancer pathway, particularly tobacco dependency pathways, preha4cancer, accelerated diagnostics and access to surgery. Each of these is highlighted within the GIRFT & NLCA report to require substantial improvement post-COVID. Given the available infrastructure, it is difficult to believe that the necessary action plans can be delivered in parallel to a screening roll out.

However, the GM Lung Health Check Working Group is currently developing a proposal for a collaborative multi-Trust Diagnostic & Treatment Centre to ensure ring-fenced access to multi-professional out-patient assessment, accelerated, co-ordinated and supported diagnostic bundles, with appropriate interventional and hybrid theatre estate to support ambitious cancer pathway performance. Education, training and workforce development are integral to its development, fully supported by Trusts, GM Cancer Alliance and the GM Health & Social Care Partnership.

This is an exciting opportunity that, in addition to delivering screening, has the potential to assist in the rapid GM recovery post-COVID by providing greater capacity, coordination, service development & delivery and workforce expansion in line with the requirements of the GM action plans. The successes of the single queue diagnostics programme can be replicated at scale embedding greater collaborative cross-Manchester working throughout all aspects of care, whilst also enabling a sustainable high quality 21<sup>st</sup> century service.

## 2. The National Lung Cancer Audit Report 2022

The National Lung Cancer Audit (NLCA) is commissioned by Healthcare Quality Improvement Project (HQIP). The NLCA is a programme of work that aims to improve the quality of care, services and clinical outcomes for patients with lung cancer in England, Scotland and Wales.

The 2022 NLCA annual report provides information on the process of care and outcomes for patients diagnosed with lung cancer between 1 January 2019 and 31 December 2020 in England.

For the 2022 NLCA Report a new methodology was required given the significant pressures placed on Public Health England from the covid-19 pandemic. This new methodology utilised the Rapid Cancer Registration Dataset (RCRD), a new phase in the evolution of the NLCA.

The original lung cancer audit dataset (LUCADA) was a standalone system of data collection, reliant upon clinicians and multidisciplinary team coordinators submitting data for analysis. In 2014, the process for data collection changed to being automated via trusts to NCRAS within PHE. The data was linked to other sources, including the Systemic Anticancer Therapy (SACT) dataset, Radiotherapy Dataset (RTDS) and Office for National Statistics (ONS) data – the latter providing diagnoses registered only via death certificates.

The RCRD is available much faster than the gold standard NLCA dataset, with a lag of 4 months, but only provides data on patients registered via trust COSD datasets. This significant change in methodology has several important implications for the interpretation of the data in this annual report:

- The dataset is smaller than previously with 83% of patients included in the 2019 cohort compared with 2018
- The patients 'missing' from the RCRD have a poorer prognosis so the 2019 and 2020 data may represent a selected cohort of patients with better outcomes
- 'Trust first seen' was not available and patients were allocated to trusts according to their COSD submission.

## Greater Manchester Lung Cancer NLCA Data 2019/2020: Diagnosis & presentation

### 2.1 Introduction

The total number of lung cancer cases registered in the RCRD from the Greater Manchester Cancer Alliance in 2019 and 2020 were 2323 and 2216 respectively. In 2018 (using the previous data analysis methodology) this was 2363.

### 2.2 Performance Status

Performance Status	2019		2020	
	GM	England	GM	England
0	18%	20%	15%	18%
1	32%	32%	29%	29%
2	21%	17%	22%	18%
3	19%	16%	22%	18%
4	5%	5%	6%	6%
Missing	4%	10%	6%	13%

It is noteworthy that GM appears to have a worse performance status distribution compared to the national aggregate data. In particular, in 2019 GM had the highest proportion of PS2 patients and in 2020 GM has the highest proportion of PS2 and PS3 patients. The target of 95% data completeness for performance status is met in 2019 and extremely close in 2020 confirming good data submission from GM.

### 2.3 Lung cancer stage distribution

Stage	2019		2020	
	GM	England	GM	England
I	25%	20%	24%	20%
II	9%	9%	8%	7%
III	20%	20%	19%	19%
IV	42%	42%	42%	44%
Missing	5%	5%	7%	10%
Emergency Presentations	29%	31%	32%	35%

GM appears to have a significantly higher proportion of patients with lung cancer diagnosed as stage I versus the national aggregate data. (4-5% above the national level of 20%, despite the covid -19 pandemic). The combined proportion of patients diagnosed with stage I and II lung cancer in GM in 2019 and 2020 was 34% and 32% respectively compared to

28% and 27% nationally. Both GM and national figures are significantly below the NHSE long term plan objectives of 75% of patients with cancer diagnosed at stage I/II.

Thus far, there does not appear to have been the stage shift to advanced stage disease from the covid-19 pandemic in GM (data does not yet include 2021) though the increase in missing data makes this harder to conclude in complete certainty. This hopefully suggests a positive impact of the processes put in place in GM to prevent late presentation and stage shift in GM but this conclusion is also limited by the analysis methodology and potential selection bias of the RCRD. Emergency presentations of lung cancer have increased during the covid-19 pandemic and may reflect a change in practice in primary care with virtual consultations and public health messaging to self-isolate with respiratory symptoms. The target of 95% data completeness for staging is met in 2019 and extremely close in 2020 confirming good data submission from GM.

### **2.4 Tobacco dependency**

GM has significantly higher active smoking rates in patients diagnosed with lung cancer compared with the England average: 2019 26% vs 21% and 2020 23% vs 18%. Given the significant evidence of benefit from treating tobacco dependency in the lung cancer pathway, it should be a top priority for the Alliance to embed tobacco dependency treatment services into every lung cancer diagnostic service.

### **2.5 Cancer Nurse Specialists (CNS)**

The NLCA has a quality standard that >90% of patients diagnosed with lung cancer are seen by a lung CNS. In GM, the performance against this standard was 88% and 83% in 2019 and 2020. The reduction in 2020 may reflect the redeployment of CNS teams during the covid-19 pandemic. GM was higher than the national aggregate data at 80% and 75% respectively.

### **2.6 Pathological diagnosis of lung cancer**

	2019		2020	
	GM	England	GM	England
Pathological diagnosis of lung cancer in PS 0-2 patients	88%	82%	78%	76%
Pathological diagnosis of lung cancer in PS 0-1 & stage I/II	90%	84%	77%	77%

In 2019 GM was achieving the ≥90% target of pathological diagnosis rate in PS 0-1, stage I/II. However, the impact of covid-19 on the pathological diagnosis of lung cancer in GM had been significant with a 13% reduction in performance. This is likely to represent a greater proportion of patients referred directly for curative intent radiotherapy without a tissue diagnosis. This is reflected in the significant drop seen in the stage I-II cohort.

### 3. Greater Manchester Lung Cancer NLCA Data 2019/2020: Curative Intent NSCLC Treatment

#### 3.1 Overall surgery & radiotherapy rates and curative treatment in PS 0-2, stage I/II

	2019		2020	
	GM	England	GM	England
Surgery in NSCLC	19%	20%	12%	15%
Surgery in NSCLC PS0-2 stage I/II	47%	58%	32%	48%
Curative intent radiotherapy in lung cancer	19%	12%	18%	11%
Curative-intent radiotherapy in NSCLC PS 0-2	37%	26%	43%	26%
<b>Curative intent treatment rate in NSCLC PS 0-2 Stage I/II</b>	<b>83%</b>	<b>81%</b>	<b>74%</b>	<b>73%</b>

There has been a significant reduction in surgical resection in NSCLC in GM in 2020 due to the covid-19 pandemic. However, the overall rate of surgery in NSCLC in 2020 in GM (12%) and the rate of surgery in stage I/II NSCLC in PS 0-2 patients in GM in 2020 (32%) is below the lower quartile range for England. **In 2020 the proportion of patients PS0-2 with stage I/II NSCLC being treated with surgery is 16% lower than the level across England.** The overall rate of surgery in NSCLC in 2019, pre-covid-19, sits below the GIRFT recommendation target of 20% but above the NLCA audit standard of 17%.

In contrast to this, GM has significantly higher overall proportion of lung cancer patients having curative-intent radiotherapy compared to the national level and this figure is above the upper quartile range in both 2019 and 2020. Furthermore, **in 2020, during the covid-19 pandemic, GM has the highest proportion of NSCLC PS 0-2 patients undergoing curative-intent radiotherapy at 43%, which is 17% higher than the level across England.** Despite the increasing proportion receiving curative-intent radiotherapy, there is an actual reduction in the numbers of treatments with curative intent. These actual numbers lay bare the impact of covid-19 as there were 96 less PS 0-2 stage I/II NSCLC patients in 2020 compared to 2019 and 142 less curative-intent treatments given in this category.

Overall, in 2019 GM was delivering close to the 85% target of PS 0-2 NSCLC stage I/II set out by NLCA and GIRFT (83% in GM in 2019). However there has been a significant drop in 2020 during covid-19, particularly in surgery, which requires urgent attention. It is noted, however that the GM performance remains just above that of England in 2020.

	2019	2020
<b>Total NSCLC PS 0-2 stage I/II NSCLC patients</b>	627	501
<b>Number NSCLC PS 0-2 Stage I/II patients having surgery</b>	279 (47%)	161 (32%)
<b>Number NSCLC PS 0-2 Stage I/II patients having curative-intent radiotherapy</b>	234 (37%)	213 (43%)
<b>Number NSCLC PS 0-2 Stage I/II patients having any curative treatment</b>	518 (83%)	371 (74%)

### 3.2 Stage III NSCLC – curative intent treatment

	2019		2020	
	GM	England	GM	England
Active treatment rate in stage III NSCLC	71%	64%	60%	58%
Stage IIIA PS 0-2 treated with chemoradiotherapy (sCRT or cCRT)	50%	37%	33%	26%
Stage IIIA PS 0-2 treated surgery & chemotherapy	13%	12%	6%	8%
Stage IIIA PS 0-2 treated with surgery alone	13%	12%	8%	11%
Stage IIIA PS 0-2 treated with radiotherapy alone	15%	10%	32%	14%
Stage IIIA PS 0-2 treated with best supportive care	13%	19%	19%	24%

Optimal treatment in stage III NSCLC is multimodality treatment combining a local treatment with a systemic treatment (chemoradiotherapy or surgery & chemotherapy). In GM the active treatment rates in stage IIIA NSCLC are higher than the England average and the rates of chemoradiotherapy are also higher than the England average. However, 50% (26/52) of all patients with stage IIIA PS 0-2 NSCLC that underwent surgery in 2019 did not undergo chemotherapy as well and in 2020 this figure was 56% (14/25). During the covid-19 pandemic caution was urged in adjuvant chemotherapy but this does not explain the high rate without chemotherapy in 2019. This warrants further exploration to ensure optimal care is being delivered in stage III NSCLC in GM. In 2020 there was a very high proportion of stage IIIA PS 0-2 patients treated with radiotherapy alone which may reflect a change in practice to reduce the risk from covid-19 (this was the highest proportion across the UK). Close monitoring of multimodality treatment of stage III NSCLC should be a priority for GM in the future.

When chemoradiotherapy is the treatment of choice in stage III NSCLC then this should be delivered concurrently rather than sequentially where possible. For all chemoradiotherapy NSCLC treatments delivered across GM the proportion that were delivered concurrently was 52% in 2019 and 44% in 2020. Both figures were above the average across England and above the upper quartile range.

#### 4. Greater Manchester Lung Cancer NLCA Data 2019/2020: Palliative-intent NSCLC Treatment

	2019		2020	
	GM	England	GM	England
SACT in Stage IIIB/IV NSCLC PS 0-1	50%	54%	48%	55%
SACT in Stage IV NSCLC	27%	33%	25%	29%
SACT in stage IV NSCLC PS 0-1	55%	60%	52%	69%

Across both time periods in GM the rate of systemic anti-cancer therapy (SACT) in advanced stage NSCLC is lower than the average across England and a long way below the national target of 65% set by the NLCA and the 70% set by the national lung cancer GIRFT report. Across England the rate of SACT increased during the covid-19 pandemic which may have reflected extraordinary access to therapies e.g. immunotherapy in PDL1 expression >1% and reduced treatment scheduling e.g. 6 weekly immunotherapy. However, in GM these rates reduced.

An action plan to optimise the uptake of SACT in advanced stage NSCLC is described within this document and includes:

- Ad hoc on-the-day tobacco dependency treatment service to be developed and implemented at The Christie for lung cancer patients and medical oncology service at Wythenshawe
- Expansion of the Prehab4cancer programme to optimise outcomes and provide equitable access including for patients with advanced stage lung cancer
- Complete a GM wide audit of adherence to the GM Reflex Testing Protocol & audit turnaround times for predictive marker testing as part of this audit – to highlight and address pathway times for this critical element of the advanced stage pathway
- Full implementation of the GM Lung Cancer Emergency Pathways protocols (**Appendix 5**)
- Ensure frailty assessment and comprehensive geriatric assessment via a specialist oncogeriatrician service is embedded within all GM medical oncology services
- Complete and implement GM Lung MDT Reform project which includes a streamlined referral protocol for patients with stage 4 disease – eligible patients can be referred directly for treatment without awaiting an MDT discussion

### 5. Greater Manchester Lung Cancer NLCA Data 2019/2020: Small cell lung cancer treatment

	2019		2020	
	GM	England	GM	England
Curative-intent multimodality treatment in stage I-III PS 0-2 SCLC (surgery & chemo or chemoradiotherapy)	73%	67%	62%	57%
SCLC & SACT	61%	69%	66%	66%
SCLC and SACT within 14 days of diagnosis	20%	16%	14%	17%

Curative intent treatment rates in SCLC are higher than the average in England. When chemoradiotherapy is the treatment of choice in SCLC then this should be delivered concurrently rather than sequentially where possible. For all chemoradiotherapy SCLC treatments delivered across GM the proportion that were delivered concurrently was 68% in 2019 and 59% in 2020. Both figures were above the average across England (51% in 2019 and 2020). However, systemic therapy is below the national average and the proportion receiving systemic therapy within 14 days of diagnosis is low and is a key performance metric to drive improvements in.

An action plan to optimise uptake of SACT in SCLC is described within this document and includes:

- Ad hoc on-the-day tobacco dependency treatment service to be developed and implemented at The Christie for lung cancer patients and medical oncology service at Wythenshawe
- Expansion of the Prehab4cancer programme to optimise outcomes and provide equitable access including for patients with advanced stage lung cancer
- Full implementation of the GM Lung Cancer Emergency Pathways protocols including the rapid referral of a new small cell lung cancer diagnosis via a dedicated proforma (**Appendix 5**)
- A new WTE small cell lung cancer GM co-ordinator to action a small cell diagnosis on day of diagnosis
- Ensure frailty assessment and comprehensive geriatric assessment via a specialist oncogeriatrician service is embedded within all GM medical oncology services

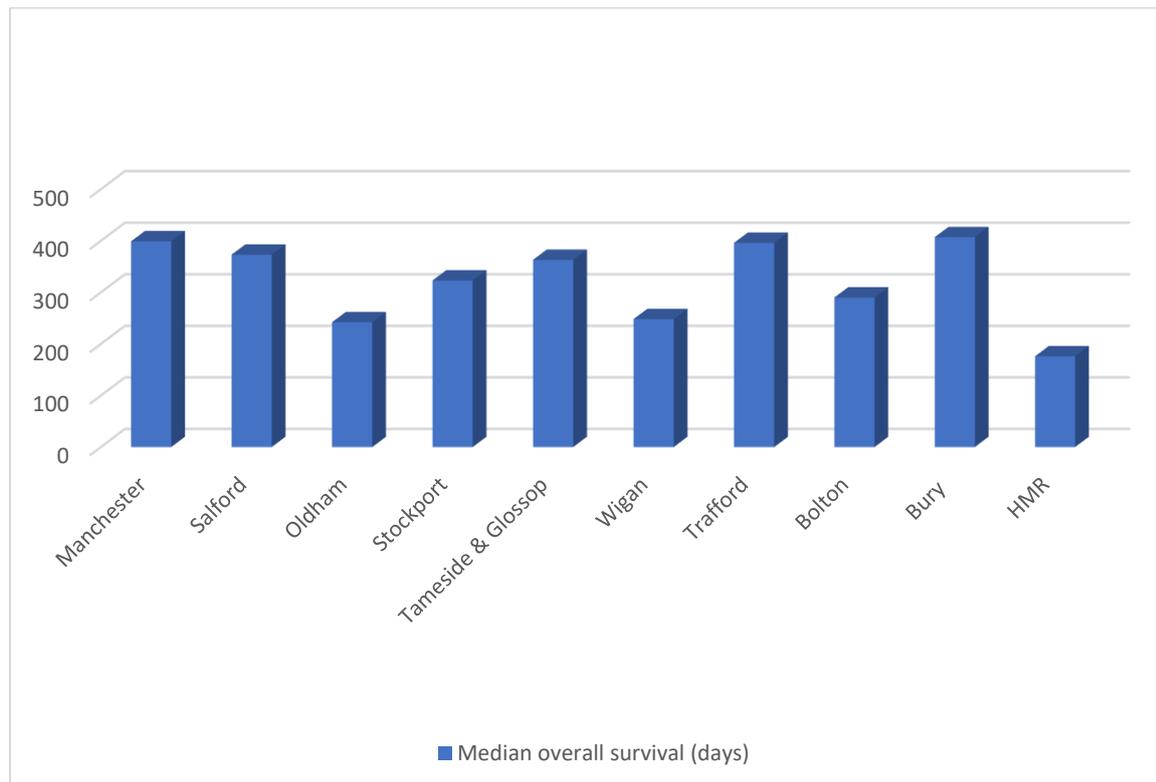
## 6. Greater Manchester Lung Cancer NLCA Data 2019/2020: Lung Cancer Survival Outcomes

### 6.1 Overall survival outcomes in GM

	2019		2020	
	GM	England	GM	England
Three-month survival from diagnosis	72%	71%	64%	64%
1-year survival from diagnosis	46%	46%	-	-
Median survival	330 days	316 days	-	-

### 6.2 Lung Cancer survival by CCG in Greater Manchester in 2019

The median overall survival in lung cancer across the ten CCGs in 2019 ranged from 176 days at the lowest and 407 days at the maximum – the highest survival rate in GM is over double that of the lowest survival rate.



The actions described within this document are designed to reduce unwarranted variation and inequality and the impact of this action plan will be monitored via the GM tableau system at locality level to ensure there has been a reduction in variation.

## 7. Greater Manchester Lung Cancer NLCA Data 2019/2020: Key messages

### Key messages: Good practice & performance in GM 2019/2020

- In 2019, prior to the covid-19 pandemic, GM was compliant or close to compliance with the following NLCA standards:
  - ≥90% pathological diagnosis in NSCLC PS 0-2 stage I/II (GM 90% and higher rates of pathological confirmation that national average in all domains)
  - >85% curative intent treatment in NSCLC PS 0-2 stage I/II (GM 83%, led by a high proportion of patients receiving curative-intent radiotherapy)
  - >17% NSCLC surgical resection rate (GM 19%, very close to achieving the GIRFT recommended 20% target)
- GM has high rates of active treatments rates and multimodality treatment rates in stage III NSCLC driven by higher than national average rates of chemoradiotherapy and curative intent radiotherapy

### Key messages: Areas of concern requiring action plan in GM

- Covid-19 has affected every performance metric in lung cancer. It has affected surgical resection rates greater than any other areas with a 15% reduction in the proportion of patients with NSCLC PS 0-2 stage I/II undergoing surgery
- Surgical resection rates in GM are lower than national rates in all domains & in 2020 are 16% below the national average in NSCLC PS 0-2 Stage I/II which is below the national lower quartile range. In 2020 the GM surgical resection rate in NSCLC has dropped to 12%.
- A high proportion of patients with stage IIIA NSCLC that undergo surgery do not undergo adjuvant chemotherapy (approximately 50-55%) and this requires further investigation and action plan to address
- Systemic anti-cancer therapy rates in advanced stage NSCLC PS 0-1 are below national rates and significantly below the NLCA target of 65% and the GIRFT recommendation of 70% (GM 50% and 48% in 2019/2020).
- Low rates of systemic anti-cancer therapy had also been seen in small cell lung cancer with GM below the NLCA and GIRFT target of 70% (GM 61% and 66% in 2019/2020). Furthermore, the proportion of patients with small cell lung cancer that commence treatment is 20% and 14% in 2019/2020 respectively – significantly below the GIRFT recommendation of 80%
- Survival outcomes in GM suggest significant variation and inequity of access to optimal care

## 8. Greater Manchester Lung Cancer NLCA Data 2019/2020: Discussion & Action plan

Greater Manchester, despite a poorer performance status cohort and higher smoking prevalence compared to England, has survival outcomes comparable to the national average. This is likely to be driven by:

- ✓ 5% higher proportion of patients diagnosed at stage I
- ✓ High curative-intent treatment rates in stage I/II driven by a high rate of curative intent radiotherapy
- ✓ Lower rate of emergency presentations of lung cancer compared to national average

The reasons that survival outcomes do not exceed national averages is likely the counterbalancing effect of low rates of systemic anti-cancer therapy across all domains.

Covid-19 has had very negative impact on lung cancer outcomes but in GM this appears to be very marked in thoracic surgery. The NSCLC surgical resection rate has dropped by 7% in GM and the proportion of PS0-2 stage I/II patients treated with surgery has dropped by 15% and sits 16% below the national figure as an outlier below the lower quartile range. A further concern in thoracic surgery is that approximately 50% of patients with stage III NSCLC do not receive adjuvant chemotherapy and therefore do not receive optimal care with multi-modality treatment.

Finally, the variation in survival across the GM localities suggests unwarranted variation and inequity of access to optimal care.

Therefore, Greater Manchester Cancer must develop an action plan that urgently re-instates the high surgical resection rate seen in GM and exceeds the GIRFT target of 20%. Optimising access to systemic therapy that includes as part of multi-modality treatment in stage III lung cancer must also represent a top priority in this action plan. The action plan is described in chapter 1 of this document.

### 3.National Lung Cancer Getting It Right First Time Report 2022

Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience, without the need for radical change or additional investment.

#### The National Lung Cancer GIRFT Report

This national report summarises a deep-dive review of NHS lung cancer services, commissioned jointly with the NHS England National Cancer Programme. Currently only around 16% of patients diagnosed with lung cancer in the UK will survive for five years or more. For many years, the lung cancer clinical community has been aware of variation in outcomes for patients, both within the UK and between other countries with similar healthcare systems. Although these outcomes have been steadily improving over the past decade, the pace of change has been relatively slow. There are now a wide variety of treatments available for patients, and this complexity means that a high level of expertise is needed within lung cancer clinical teams in order to appropriately characterise the type and the stage of the tumour, to assess a patient's fitness for treatment and to deliver these therapies with maximum effect and minimal toxicity. Ensuring that all patients have equitable access to this expertise, as well as to all the available diagnostic and therapeutic modalities, is a consistent theme of this report. The GIRFT team accessed a number of detailed datasets which, along with the deep-dive visits to teams, tells a comprehensive story of the variability in lung cancer care across England.

Using the datasets available & informed further by the deep-dive discussions with teams on GIRFT visits across England, the report makes **33 recommendations** for local, regional and national prioritisation, focusing particularly on the following aspects of lung cancer care which offer the most significant opportunities for improvements in outcome:

- Making a rapid and precise diagnosis
- Delivering effective treatment
- Effective multidisciplinary working
- Improving data and information
- Resources, organisation and accountability.

This report reviews all of the GIRFT recommendations to reflect on the work completed to date in Greater Manchester to implement these recommendations and develop an action plan to complete this implementation.

## 1 GIRFT: Making a rapid and precise diagnosis

GIRFT Recommendation	GM work to date	GM Action
Respiratory teams to immediately move to providing proactive management of unexpected abnormal chest radiology and work with radiology departments to implement pathways that deliver a three working day turnaround from abnormal chest X-ray or referral to CT scan report.	<ul style="list-style-type: none"> <li>£1.3 million transformation funding 2019-2021 to implement patient navigators &amp; best-timed pathway</li> <li>GM strategy to promote earlier diagnosis of lung cancer and optimise the front end of the pathway agreed Feb 2022</li> </ul>	<ul style="list-style-type: none"> <li>Full implementation of the GM strategy for earlier diagnosis &amp; optimising outcomes in lung cancer: getting the front end of the pathway right (<b>Appendix 1</b>)</li> <li>Progress pilot projects in patient-led direct access to CXR and AI CXR reporting in development and complete robust evaluation</li> </ul>
Key diagnostic investigations should be completed within 21 calendar days of the start of the pathway by adopting best practice recommendations on service configuration and pathway planning.	<ul style="list-style-type: none"> <li>GM diagnostic bundles implemented as standard of care (referenced as standard of care in the GIRFT report) since 2018</li> <li>£1.3 million transformation funding 2019-2021 to implement patient navigators &amp; best-timed pathway</li> </ul>	<ul style="list-style-type: none"> <li>Ensure all GM lung cancer physician teams have daily job planned time for daily triage and 'board round' of all patients on the lung cancer pathway</li> <li>GM medical director to write to all respiratory clinical directors to support job planning process</li> </ul>
Renegotiate the national PET-CT contract to include a five calendar day turnaround from request to report and available imaging for initial investigations of new diagnoses of lung cancer.	<ul style="list-style-type: none"> <li>Direct telephone booking into next available appointment rolled out across three of four sectors in GM</li> </ul>	<ul style="list-style-type: none"> <li>Complete roll out of direct telephone booking to next available slot across all GM sectors</li> <li>Develop telephone booking service into a single point of contact with access to all PET scanners for all GM patients</li> <li>GM PET team to ensure test images are available to clinical teams on same day as the scan is reported</li> <li>GM to develop a single digital platform for specialist cancer diagnostics bookings and results that include PET, EBUS, CT lung biopsy</li> </ul>

<p>An image-guided biopsy service should be available for all patients 52 weeks of the year, with appointments for the procedure being available (notwithstanding issues such as anti-coagulation or anti-platelet therapy) within five working days of the request.</p>	<ul style="list-style-type: none"> <li>Regional biopsy service available at GM thoracic centre (referenced in the GIRFT report)</li> </ul>	<ul style="list-style-type: none"> <li>Develop a single queue lung biopsy service for GM to maximise assets &amp; capacity</li> <li>GM to develop a single digital platform for specialist cancer diagnostics bookings and results that include PET, EBUS, CT lung biopsy</li> </ul>
<p>EBUS for lung cancer should be available within five calendar days of request and must comply with the national service specifications, with regular monitoring of performance by local commissioners.</p>	<ul style="list-style-type: none"> <li>GM has produced regional EBUS performance reports since 2016</li> <li>Single queue EBUS service piloted in 2021 (<b>Appendix 6</b>)</li> </ul>	<ul style="list-style-type: none"> <li>Develop and implement the single queue EBUS service across all of GM</li> <li>The single queue system should, in the future, provide the data for performance review</li> <li>GM to develop a single digital platform for specialist cancer diagnostics bookings and results that include PET, EBUS, CT lung biopsy</li> </ul>
<p>Ensure a diagnostic and therapeutic ambulatory pleural service is available for all lung cancer patients, accessible within five working days, 52 weeks of the year.</p>	<ul style="list-style-type: none"> <li>GM clinical lead has led the development &amp; running of the 1st BTS Pleural Service Organisational Audit in 2021</li> </ul>	<ul style="list-style-type: none"> <li>GM review of National BTS Organisational Audit of Pleural services 2021 – review GM trusts providing diagnostic and therapeutic pleural services</li> <li>Include specialist pleural diagnostics in the regional single queue digital platform</li> </ul>
<p>Pathological services should provide a maximum ten calendar day turnaround time for molecular profiling according to the national test directory of lung cancers to meet the requirements of the NOLCP.</p>	<ul style="list-style-type: none"> <li>GM Reflex Testing Protocol agreed and implemented in 2021 (<b>Appendix 7</b>)</li> </ul>	<ul style="list-style-type: none"> <li>Complete a GM wide audit of adherence to the GM Reflex Testing Protocol</li> <li>Audit turnaround times for predictive marker testing as part of this audit</li> </ul>

## 2 GIRFT: Delivering Effective Treatment

GIRFT Recommendation	GM work to date	GM Action
All trusts should have an overall radical treatment rate of 85% or more in those patients with NSCLC stages I-II and of performance status 0-2. This includes all treatment modalities (surgery, radiotherapy including SABR, multimodality treatment and thermoablative techniques).	<ul style="list-style-type: none"> <li>• Business case approval for a one-stop lung cancer clinic for patients suitable for curative intent treatment with surgery but deemed at higher risk (surgeons, anaesthetists, oncologists, oncogeriatrics)</li> </ul>	<ul style="list-style-type: none"> <li>• Launch and evaluate the GM One Stop Lung Cancer Clinic (<b>Appendix 4</b>)</li> <li>• GM spotlight audit NSCLC stage I/II PS0-2 2021</li> <li>• GM thermoablative service to be developed. Currently inadequate &amp; underutilised provision/access</li> </ul>
All trusts should have an overall surgical resection rate for NSCLC of over 20%.	<ul style="list-style-type: none"> <li>• Surgical HRMDT implemented since 2012 in GM</li> <li>• Business case approval for a one-stop lung cancer clinic for patients suitable for curative intent treatment with surgery but deemed at higher risk (surgeons, anaesthetists, oncologists, oncogeriatrics)</li> <li>• Prehab4cancer service available for all lung cancer surgical patients from 2019</li> <li>• CURE tobacco dependency team available ad-hoc in all thoracic surgical clinics from 2021 and results presented at BTOG (44% quit rate)</li> </ul>	<ul style="list-style-type: none"> <li>• Launch and evaluate the GM One Stop Lung Cancer Clinic (<b>Appendix 4</b>)</li> <li>• GM spotlight audit on prehab4cancer referrals for eligible patients</li> <li>• Integrate Prehab4cancer team into clinical service e.g. presence in one-stop lung cancer surgery, feedback on prehab progress during HRMDT discussions.</li> <li>• Development of a 'central tumour pathway' to fast track patients with a central tumour suitable for surgery but at risk of becoming unresectable without an urgent pathway</li> </ul>
All trusts that treat lung cancer with radiotherapy should be able to deliver SABR in line with the clinical commissioning policy.	<ul style="list-style-type: none"> <li>• Good access to SABR across GM and a centralised SABR MDT in operation</li> <li>• NLCA 2019/2020 shows highest rate of radical radiotherapy in GM across the UK</li> </ul>	<ul style="list-style-type: none"> <li>• No specific action</li> </ul>
All trusts should deliver radiotherapy in line with the RCR consensus statements	<ul style="list-style-type: none"> <li>• IMRT/IGRT/4D XRT used as standard in GM</li> <li>• NLCA 2019/2020 shows highest rate of radical radiotherapy in GM across the UK</li> <li>• All XRT patients (PS 0-2, CFS ≤5) eligible for curative-intent treatment are eligible for prehab4cancer from 2020</li> </ul>	<ul style="list-style-type: none"> <li>• No specific action</li> </ul>
Where a patient has early stage disease but is declined for radical treatment, or does not have access	<ul style="list-style-type: none"> <li>• Surgical HRMDT implemented since 2012 in GM &amp; provides second opinion</li> <li>• Business case approval for a one-stop lung</li> </ul>	<ul style="list-style-type: none"> <li>• No specific action</li> </ul>

<p>to the full range of radical treatment options, more effective mechanisms should exist for a second opinion</p>	<p>cancer clinic for patients suitable for curative intent treatment with surgery but deemed at higher risk (surgeons, anaesthetists, oncologists, oncogeriatrics)</p>	
<p>Trusts should monitor rates of post-surgical adjuvant and neoadjuvant treatments and this data should be available for national benchmarking.</p>	<ul style="list-style-type: none"> <li>Not a metric previously measured by GM</li> </ul>	<ul style="list-style-type: none"> <li>Use ethically approved North-West Surgical Outcomes Database to review adjuvant rates dating back to 2012 lead by surgical centre</li> <li>Discuss modified prehab-rehab service for patients known to require adjuvant chemo post- surgery e.g. stage III NSCLC</li> </ul>
<p>Trusts should record and monitor multimodality treatment in stage IIIA disease and offer radical intent treatment as standard in fit patients.</p>	<ul style="list-style-type: none"> <li>GM Diagnostic algorithms in use since 2018 embedding EBUS/brain imaging in stage III</li> <li>GM trimodality treatment pathway in use since 2021 (<b>Appendix 8</b>) and first six patients presented at BTOG</li> <li>Business case approval for a one-stop lung cancer clinic for patients suitable for curative intent treatment with surgery but deemed at higher risk (surgeons, anaesthetists, oncologists, oncogeriatrics) – this will include stage III patients</li> <li>All stage III patients (PS 0-2, CFS ≤5) eligible for curative-intent treatment are eligible for prehab4cabcer from 2020</li> </ul>	<ul style="list-style-type: none"> <li>Use ethically approved North-West Surgical Outcomes Database to review adjuvant rates dating back to 2012 lead by surgical centre</li> <li>Review and share prehab4cancer outcomes in oncology patients (XRT,sXRT,cCRT) &amp; GM spotlight audit on prehab4cancer referrals for eligible patients</li> </ul>
<p>All trusts should improve their treatment rates with SACT to achieve greater than 70% treatment for fit patients with advanced NSCLC, and greater than 70% chemotherapy rates in SCLC.</p>	<ul style="list-style-type: none"> <li>Oncogeriatrician embedded in surgery and oncology services across GM but a single person currently.</li> </ul>	<ul style="list-style-type: none"> <li>GM to explore expansion of prehab4cancer into advanced stage lung cancer to provide equity of benefit for all patients</li> <li>GM to embed frailty assessment and comprehensive geriatric assessment as standard across all treatment services – The Christie and Wythenshawe</li> </ul>
<p>Ensure that all patients with lung cancer have access to enhanced supportive care and/or specialist palliative care. Inpatient specialist</p>	<ul style="list-style-type: none"> <li>Prehab4cancer is available for all patients with lung cancer (PS 0-2, CFS ≤5) eligible for curative intent treatment – surgical and oncology treatments</li> </ul>	<ul style="list-style-type: none"> <li>Ad hoc on-the-day tobacco dependency treatment service to be developed and implemented at The Christie for lung cancer patients.</li> </ul>

<p>palliative care provision should be available seven days per week.</p>	<ul style="list-style-type: none"> <li>• HNA embedded into practice across GM</li> <li>• CURE tobacco dependency teams have been implemented across all trusts in GM and can provide tobacco dependency treatment in lung cancer services</li> <li>• CURE provides adhoc review on the day of surgical clinic for lung cancer surgery patients (quit rate 44% in this setting – BTOG 2022)</li> <li>• Greater Manchester Medicines Management Group (GMMM) have published regional tobacco dependency treatment protocol</li> </ul>	<ul style="list-style-type: none"> <li>• All clinicians in GM lung cancer MDTs to complete either RCP Medical Management of Tobacco Dependency e-learning module or NCSCT training</li> <li>• GMMM tobacco dependency treatment protocol to implemented across lung cancer teams</li> </ul>
<p>Produce and implement protocols for follow-up pathways following radical therapies.</p>	<ul style="list-style-type: none"> <li>• GM has agreed protocols for follow up after curative intent thoracic surgery and radiotherapy: LNC-PATH and ASSENT protocols (<b>Appendix 9 &amp; 10</b>)</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluation &amp; publication of the impact of LNC-PATH on outcomes (LNC-PATH in operation since 2018)</li> </ul>
<p>Clinical trial recruitment should be considered a focus for prioritisation, with MDTs collaborating to offer a wider regional portfolio.</p>	<ul style="list-style-type: none"> <li>• Strong research portfolio in GM including lung health check recruitment</li> </ul>	<ul style="list-style-type: none"> <li>• No specific action</li> </ul>

### 3 GIRFT: Effective multidisciplinary working

GIRFT Recommendation	GM work to date	GM Action
Review operational arrangements for multidisciplinary working to ensure it is as timely, efficient, and effective as possible and meeting the needs of patients.	<ul style="list-style-type: none"> <li>GM has worked in 4 lung cancer sector MDTs since 2014</li> <li>MDT reform process has begun in GM that includes an updated sector MDT charter, a patient's voice component, and streamlined referral protocols (referral prior to MDT when criteria met)</li> </ul>	<ul style="list-style-type: none"> <li>Complete MDT reform project</li> </ul>
Improve timeliness and effectiveness of communication from the MDT to lung cancer patients and primary care.	<ul style="list-style-type: none"> <li>Post MDT clinic (within 24 hours) is standard of care in GM</li> </ul>	<ul style="list-style-type: none"> <li>GM ambition to deploy a GM digital cancer MDT platform which could rapidly communicate with primary care &amp; link with specialist cancer diagnostics platform.</li> </ul>

### 4 GIRFT: Improving data and information

GIRFT Recommendation	GM work to date	GM Action
Continue the National Lung Cancer Audit in the long-term in order to quality assure and improve services and bring the clinical community together with a shared purpose.	<ul style="list-style-type: none"> <li>No specific action</li> </ul>	<ul style="list-style-type: none"> <li>No specific action</li> </ul>
Monitor and performance manage trusts according to the key time points within the National Optimal Lung Cancer Pathway.	<ul style="list-style-type: none"> <li>GM is developing a bespoke dataset to examine the individual components of the cancer pathway</li> </ul>	<ul style="list-style-type: none"> <li>Complete GM lung cancer pathway dashboard that includes the metrics of: 72hrs CXR to CT, 21 days to MDT discussion and 49 days to commence treatment</li> <li>Full implementation of the GM strategy for earlier diagnosis in symptomatic lung cancer (Appendix 2)</li> </ul>
Collect, analyse and publish an agreed EBUS dataset aligned to agreed performance metrics and	<ul style="list-style-type: none"> <li>GM has led this process for several years and produces regular performance reports</li> </ul>	<ul style="list-style-type: none"> <li>Develop and implement the single queue EBUS service across all of GM</li> <li>The single queue system should, in the</li> </ul>

standards.		<p>future, provide the data for performance review</p> <ul style="list-style-type: none"> <li>• GM to develop a single digital platform for specialist cancer diagnostics bookings and results that include PET, EBUS, CT lung biopsy</li> </ul>
Improve the annual review of data within lung cancer services.	<ul style="list-style-type: none"> <li>• MDT reform process has begun in GM that includes an updated sector MDT charter, a patient's voice component, and streamlined referral protocols (referral prior to MDT when criteria met)</li> </ul>	<ul style="list-style-type: none"> <li>• Incorporate an MDT annual review framework into the GM Lung MDT reform work for all sector MDTs to implement</li> </ul>
Develop more relevant and generalisable methods of collecting data on patient-reported experience and outcomes.	<ul style="list-style-type: none"> <li>• A pilot experience of care pilot project has begun in GM at one trust (Wythenshawe Hospital) of the Safe-7 survey – co-produced with patients of GM – begun January 2022</li> </ul>	<ul style="list-style-type: none"> <li>• Complete and evaluate Safe-7 patient experience survey</li> </ul>

## 5 GIRFT: Resources, organisation and accountability

GIRFT Recommendation	GM work to date	GM Action
Ensure all lung cancer MDTs have a named clinical lead for the service, with job planned time for the role to allow for service development and management.	<ul style="list-style-type: none"> <li>• This is standard practice in GM</li> </ul>	<ul style="list-style-type: none"> <li>• No specific action</li> </ul>
Ensure all lung cancer MDTs have appropriately skilled practitioners across the whole range of medical, nursing and allied health professions and healthcare scientists, able to give the same levels of high-quality care to all patients in all areas of the country 52 weeks of the year.	<ul style="list-style-type: none"> <li>• GM works in four sector MDTs of 3-4 hospitals each, always allowing specialist clinician cross-cover and quorate membership</li> </ul>	<ul style="list-style-type: none"> <li>• No specific action</li> </ul>
Review the process for funding allocations to ensure that transformation funding is used as effectively as possible.	<ul style="list-style-type: none"> <li>• GM has shown strong leadership in meaningful transformation programmes including CURE &amp; prehab4cancer</li> </ul>	<ul style="list-style-type: none"> <li>• No specific action</li> </ul>

Roll out national implementation of risk-based CT screening for lung cancer.	<ul style="list-style-type: none"> <li>GM has three active LHC programmes in North Manchester, Tameside &amp; Glossop and Salford</li> </ul>	<ul style="list-style-type: none"> <li>GM is progressing a major business case to develop a GM wide LHC programme and a 'Diagnostic &amp; Treatment Centre' to manage the outflow from screening. This must be progressed at pace.</li> </ul>
Ensure that a clinical reference group continues to be available to provide strategic and clinical advice.	<ul style="list-style-type: none"> <li>GM is represented at the national CEG</li> </ul>	<ul style="list-style-type: none"> <li>No specific action</li> </ul>

## 6 National Lung Cancer GIRFT Report 2022: Covid-19 & Lung Cancer

GIRFT Recommendation	GM work to date	GM Action
National bodies and local lung cancer services should continue to respond to the challenges presented by the COVID-19 pandemic.	<ul style="list-style-type: none"> <li>GM has developed and ran the 'Do it For Yourself' public awareness campaign</li> </ul>	<ul style="list-style-type: none"> <li>Full implementation of the GM strategy for earlier diagnosis in symptomatic lung cancer (Appendix 2)</li> </ul>

### **Making a rapid and precise diagnosis**

- ✓ Full implementation of the GM strategy for earlier diagnosis in symptomatic lung cancer (Appendix 1)
- ✓ Full implementation of the GM strategy for an accelerated diagnostic & staging lung cancer pathway (**Appendix 2**), including deployment a GM digital platform for single queue booking and reporting for specialist cancer diagnostics

### **Delivering effective treatment**

- ✓ Launch and evaluate the GM One Stop Lung Cancer Clinic
- ✓ Expansion of a GM thermoablative service to optimise outcomes and provide equitable access
- ✓ Expansion of the Prehab4cancer programme to optimise outcomes and provide equitable access
- ✓ Development of a central tumour pathway

### **Effective multidisciplinary working**

- ✓ Complete and implement GM Lung MDT Reform project

### **Improving data and information**

- ✓ Complete GM lung cancer pathway dashboard that includes the metrics of: 72hrs CXR to CT, 21 days to MDT discussion and 49 days to commence treatment

### **Resources, organisation and accountability**

- ✓ Progress and accelerate a GM-wide roll out of the Lung Health Check Programme and approval of GM Diagnostic & Treatment Centre

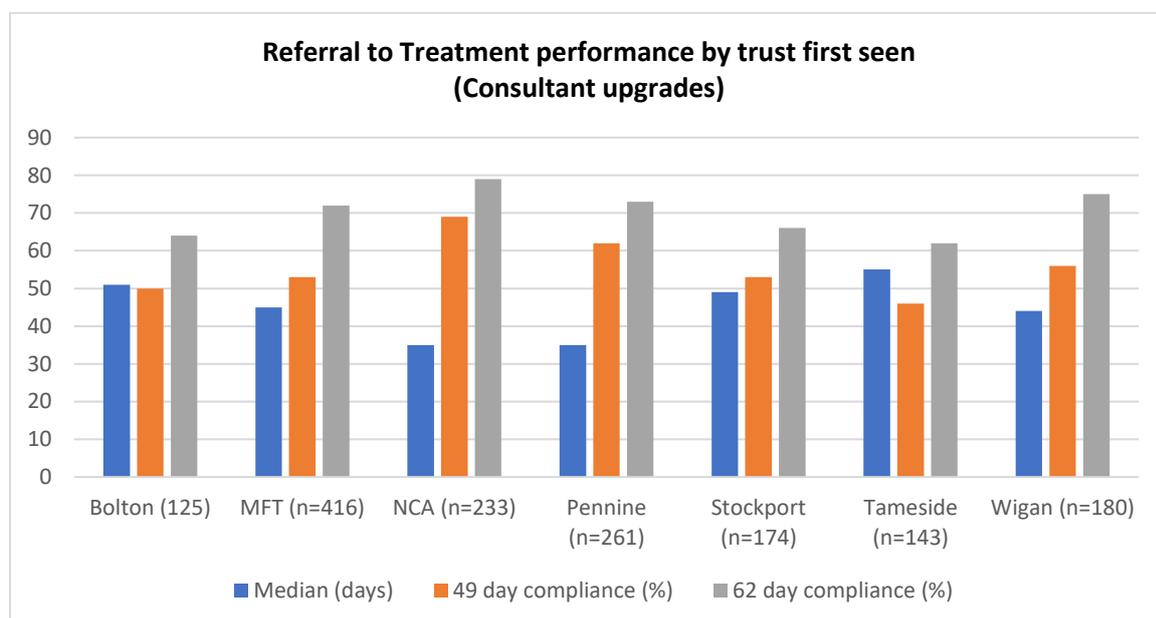
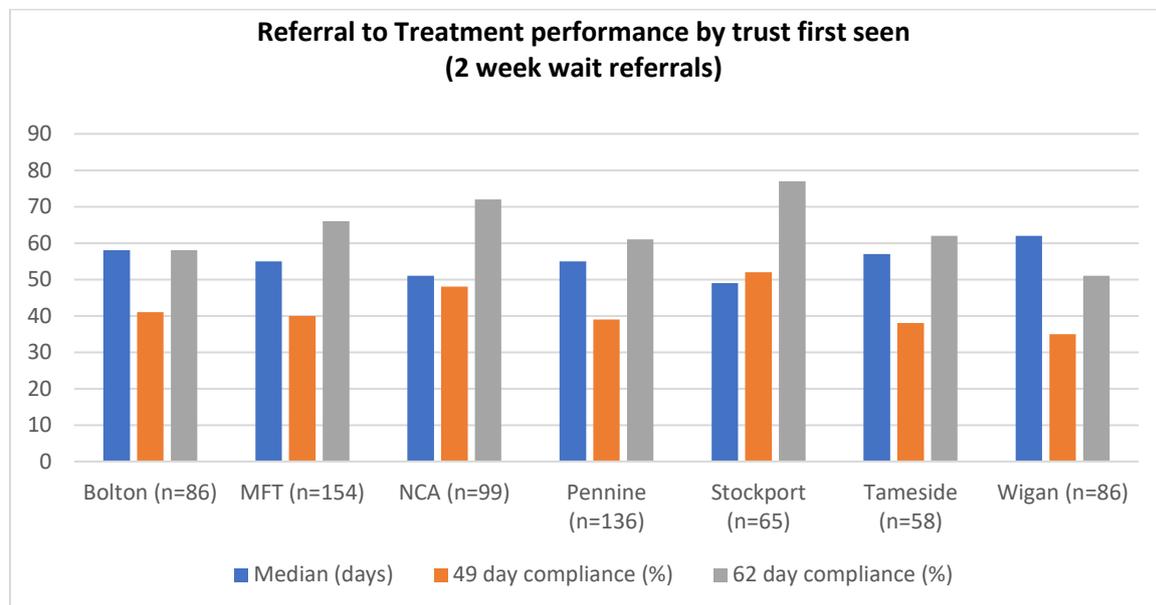
## 4 GM Lung Cancer Data – GM Tableau Dashboard

Greater Manchester cancer has created a 'live' cancer performance dashboard using the platform tableau. This data is sourced from provider cancer systems including the Somerset dataset. Following a process of pseudo-anonymisation, the data is made available to GM Business Intelligence. The BI team construct a line of data that contains the entire pathway using the huge volume of available information and this is the pathway based data source. The BI team then look at specific milestones in the data (referral, date first seen, decision to treat, treatment, etc) to construct an event based dataset and display this information in Tableau.

### 4.1 GM performance 2021 (01/01/2021 – 31/12/2021)

	<b>Two week wait referrals n=687</b>	<b>Consultant upgrade n=1551</b>
<b>Referral to first MDT – median</b>	26 days	15 days
<b>Referral to first MDT – compliance with 21 day standard</b>	37%	66%
<b>Referral to first treatment – median</b>	55 days	44 days
<b>Referral to first treatment - compliance with 49 day standard</b>	41%	56%
<b>Referral to first treatment - compliance with 62 day standard</b>	63%	71%
<b>DTT to surgery – median</b>	18 days	20 days
<b>DTT to surgery – compliance with 21 day standard</b>	67%	56%
<b>DTT to radiotherapy – median</b>	16 days	19 days
<b>DTT to radiotherapy – compliance with 16 day standard</b>	50%	39%
<b>DTT to SACT – median</b>	8 days	7 days
<b>DTT to SACT – compliance with 14 day standard</b>	84%	78%

#### 4.2 Performance by provider (hospital first seen)



This 'live' data confirms GM does not comply with the 62 days pathway target of 85% nor the 49 day national optimal lung cancer pathway. This supports GM ambitions to focus on single queue specialist cancer diagnostics system to improve efficiency in the cancer pathway. It also suggests the low systemic anti-cancer therapy levels in GM are unlikely due to pathway way delays from the decision to treat and supports the approach to investigate the pathway prior to a decision to treat (audit of reflex testing and predictive marker testing) and the optimisation of patients through an expansion to the prehab4cancer pathway.

## 5. Investment paper 1: Delivery of an expanded prehab4cancer programme in the GM Lung cancer pathway

This investment request detail the requirements to expand the GM prehab4cancer service to deliver the following objectives:

- Integrate the P4C exercise specialists into the GM One-stop lung cancer clinic to optimise uptake for patients undergoing curative intent treatment and support an increase in surgical resection rates
- Deliver a bespoke pathway of prehab-prehab-rehab for patients undergoing surgery and then adjuvant chemotherapy that facilitates re-referral into the programme from the moment of hospital discharge after surgery and support an increase in adjuvant chemotherapy rates
- To deliver prehab4cancer for patients with advanced stage lung cancer undergoing systemic therapy and increase systemic therapy rates.

<b>Service specification extension 1:</b> Increased Prehab4Cancer team capacity to integrate into the new one-stop lung cancer clinic, running twice a week (52 weeks of the year) at Wythenshawe hospital, from April 2022.		
<b>Description:</b>	<b>Organisation:</b>	<b>Costs (salary + on-costs):</b>
Level 4 Exercise Specialist 0.4 WTE (two days per week to prepare and attend the one stop clinic at Wythenshawe hospital)	Salford Community Leisure (SCL)/GM Active	£12,059.82
<b>Sub-Total:</b>		<b>£12,059.82</b>

<b>Service specification extension 2:</b> Prehab4Cancer and rehabilitation programme eligibility criteria to be extended to include referrals for people diagnosed with advanced stage lung cancer disease (IIIB/IV). Approximately 500 patients per year. Increased capacity within the existing service provision (including staff members and gym memberships). Recognition of the increased nutritional and psychological needs of this patient group have been reflected in the below ask.		
<b>Description:</b>	<b>Organisation:</b>	<b>Costs (salary + on-costs):</b>
<b>Level 4 Exercise Specialist 2.0 WTE</b> (£25,991.00 per member of staff + 16% on costs)	SCL/GM Active	£60,299.12
<b>Consultant Clinical Psychologist (B8c) (Cancer specialist) 3 hours per month</b> (This will include providing 2 reflective sessions of approx. 90 mins, every 6 weeks + formal and regular support to the P4C programme manager + ad-hoc	GM Mental Health NHS Foundation Trust.	Approx. £1528.20

support to the P4C team regarding specific patients who need to be escalated related to psychological needs)		
<b>Band 7 Specialist Dietitian 1.0 WTE</b> (to be based at the Christie and/or Wythenshawe hospital and offer out-patient/community/remote/virtual assessment and intervention appointments as well as advice/consultancy to the Prehab4Cancer team)	Christie or Wythenshawe (MFT)	£52,800.00
<b>Refer-all licence fee x 3</b> (Exercise Specialists + Dietitian)	SCL/GM Active	£1500.00
<b>Gym membership</b> (6 months x 350 patients. 1 month = £25)	SCL/GM Active	£52,000.00
<b>Sub-Total:</b>		<b>£168,127.32</b>

<b>Service specification extension 3:</b> Bespoke pathway for patients planned for surgery and then chemotherapy - provide early contact and support after surgery and support progression onto adjuvant chemotherapy (with increased tolerance to chemo regimes)	
This extension be provided by increased team capacity described for service specification extension 1 & 2. It would involve increased interdisciplinary team working with AHP teams at Wythenshawe hospital discharging patients post-surgery. This could be facilitated as a component of the Level 4 Exercise Specialist time in-reaching to the one stop clinic.	
<b>Description:</b>	<b>Costs:</b>
Absorbed into existing service provision, supported by extensions described above.	0
<b>Sub-Total</b>	
<b>£0</b>	

<b>Support staff</b>		
A full-time referral coordinator/administrator would need to be employed to support the above 3 service specification extensions. This is due to the increased volume of referrals the service would receive and the cross checking required to ensure all eligible lung cancer patients have been referred to the service (this particularly relates to those patients accessing the one stop clinic).		
A Cancer Intelligence analyst would be required to support the monitoring of performance in the lung cancer pathway, evaluation, and evidence of impact of the extensions described.		
<b>Description:</b>	<b>Organisation:</b>	<b>Costs:</b>
<b>Referral Coordinator/Administrator 1.0 WTE</b>	SCL/GM Active	£20,493.00
<b>Refer-all licence fee x1</b>	SCL/GM	£500.00
<b>B6 Cancer Intelligence Analyst 1.0 WTE</b>	GM Cancer alliance (hosted by the Christie)	£42,655.00
<b>Sub-Total:</b>		<b>£63,648.00</b>

<b>Total Cost:</b>	<b>£243,835.14</b>
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\*All NHS costs are based on AfC 21/22 payscales at midpoint.

Investment paper prepared by:	
Dr Matt Evison	GM Cancer Lung Pathway Board Clinical Lead and Prehab4Cancer Lung subgroup Chair
Dr John Moore	Prehab4Cancer and Recovery programme Clinical Lead
Zoe Merchant	Prehab4Cancer and Recovery programme AHP Lead
Kirsty Rowlinson-Groves	GM Active Prehab4Cancer Programme Manager
Supported by Prehab4Cancer steering group including Dr Padraig McDonnell, and wider stakeholders including dietetic team at the Christie and cancer intelligence team within GM Cancer.	

## 6. Investment paper 2: An adjuvant chemotherapy patient navigator & a post resection MDT at the regional thoracic surgery centre

Currently in the Lung Cancer & Thoracic Surgery Directorate there are concerns about the processes and pathways in place after a patient has completed surgical resection of lung cancer. These issues translate into poor patient experience, patient harms and inefficient use of staff time. Current processes are described below:

- When a patient is discharged from hospital a discharge summary is sent to the GP and local lung cancer nurse specialist (CNS) team (not to the hospital-based parent team – e.g. external trust clinicians that have referred the patient for lung cancer surgery)
- The thoracic nursing staff check all new pathology reports daily for any new pathological results from the specimens removed at the time of surgery. Based on the final reported stage of the cancer the nurses will decide if a referral for adjuvant treatment is needed (e.g. chemotherapy after surgery). **This is time sensitive as adjuvant therapy needs to commence within a certain timeframe after surgery and also time intensive as a daily task for the thoracic nursing team.**
- If adjuvant treatment might be needed a proforma is completed and sent to the oncology team and the patient is phoned with this outcome (with a copy sent to the local CNS team).
- A routine post-surgery outpatient clinic appointment is made for all patients after lung cancer surgery (approximately 4-6 weeks post-surgery). A manual process exists to ensure the pathology results will be available when the patient is seen in the surgical clinic.
- Patients are discharged from surgery to either the oncology team for adjuvant treatment or to the parent hospital team for 5-year surveillance after this surgical outpatient review – however it might not be known at this stage whether adjuvant treatment is required.
- Patients requiring adjuvant treatment will be given a new patient appointment in the oncology clinic. However, there may be missing information or complex issues (operation note, surgical margins, gross surgical pathology and clarification of resection status) required in order to progress the care of this patient and the oncologist frequently organises a discussion in the lung cancer treatment MDT. Consequently, the oncologist is not in a position to provide clarity in relation to whether adjuvant treatment is required, the type of treatment or its potential impact. Following review by the oncologist, a decision may be made that adjuvant treatment is not required.
- This is an already stretched lung cancer MDT, primarily designed to discuss the treatment of new cases of lung cancer.
- The 2019/2020 NLCA data report identified that 50-55% patients in Greater Manchester with stage III NSCLC that underwent surgery did not proceed to

complete their optimal treatment with adjuvant chemotherapy. Process and pathways are not in place to optimise the uptake of adjuvant chemotherapy after surgery or monitor adherence to adjuvant chemotherapy.

These processes risk poor patient experience, delayed treatment, patient harms, suboptimal communication with inefficient use of staff time and poor adherence to adjuvant chemotherapy. The following negative impacts have occurred due to these processes:

- Poor communication with referring trusts – parent teams often not informed of pathology results, need for adjuvant treatment and progress after surgery. This can create difficulties if the patient requires input from the local Cancer Nurse Specialist or hospital team and they are not up to speed with the latest information
- Patients receive important information via a telephone call, do not receive full and complete information at outpatient appointments and can have consultations with oncologists without being able to make treatment decisions. Lack of an MDT discussion can mean patients have to attend an oncology appointment that would not have been required had an MDT discussion taken place. This can cause unnecessary anxiety for the patient.
- Patients have been lost to follow-up because of incomplete or missed referrals back to the referring team. At Wythenshawe two patient harm incidents have been investigated including a severe harm where due to a lack of referral back to the parent team and therefore no appropriate follow-up there was a missed opportunity to diagnose a second new lung cancer. The cancer had already spread to the lymph nodes by the time it was found which will impact the chances of being able to cure this second lung cancer.
- Improved post-operative processes might have prevented a level 5 harm incident in which a patient with two synchronous lung cancers needing two treatments completed her first surgery at Wythenshawe but then was not referred back for their second treatment at the appropriate time and the cancer became untreatable.

It is therefore clear that a robust mechanism and pathway is required to manage the review of pathology from lung cancer surgery, ensure appropriate & timely decision making about adjuvant treatment and deliver exceptional patient experience with efficient use of NHS resources.

### **Proposed solution**

The Lung Cancer & Thoracic Surgery Directorate at Wythenshawe Hospital proposes to address these issues with the launch of a **Post-Lung Cancer Resection MDT** and an **'Adjuvant chemotherapy patient navigator'**.

The navigator will identify thoracic surgery referrals with an indication for adjuvant chemotherapy and ensure access to the dedicated surgery-adjuvant chemotherapy prehab-rehab pathway with the GM prehab4cancer team (this includes re-referral to the team and provision of a discharge exercise kit, such as resistance bands, to begin preparation for adjuvant chemotherapy immediately on discharge). Those with post-operative complications and prolonged lengths of stay will be identified and offered early physician review in the Wythenshawe lung cancer survivorship to optimise recovery and progress to adjuvant chemotherapy. Patients identified for adjuvant chemotherapy only on following pathological staging will be contacted immediately to offer prehab4cancer and identify issues that could be addressed to optimise the uptake of adjuvant chemotherapy. The navigator will lead on the development of bespoke patient information on adjuvant chemotherapy to be provided to all patients with an indication for adjuvant chemotherapy as a standard of care. Finally, the navigator will have responsibility for preparation of post-resection MDT forms for documenting MDT outcomes and following up on actions from the MDT, ensuring close communication with parent teams across GM.

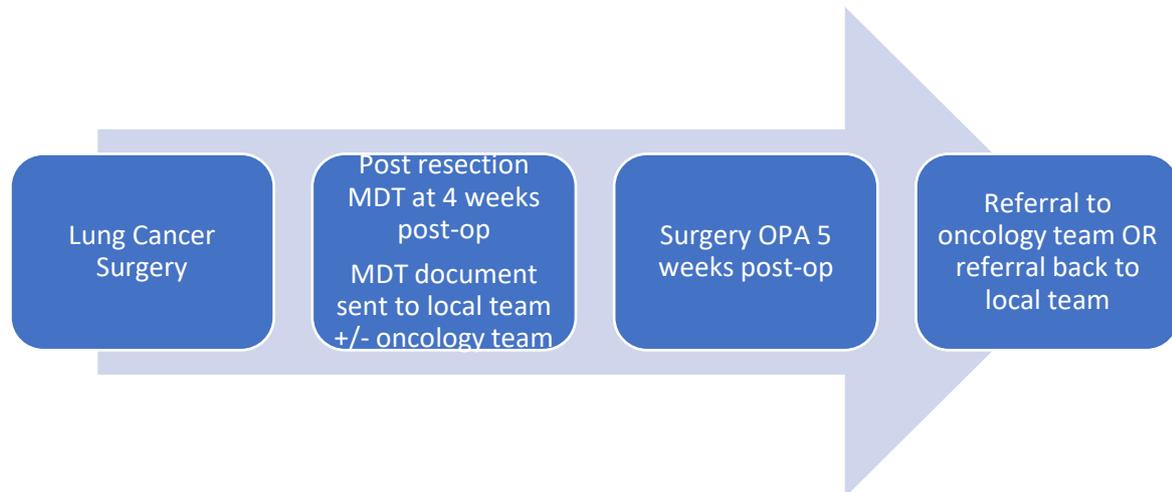
The post-lung cancer resection MDT will be a 2-hour weekly meeting that will discuss approximately 10 cases per week (approximately 500 lung cancer resections per year at Wythenshawe). Attendees will time for any post MDT actions and admin to be completed. The MDT will consist of:

- Lung cancer physician
- Thoracic Surgeon
- Thoracic radiologist (will require 1xPA preparation time)
- Thoracic pathologist (will require 1xPA preparation time)
- Clinical Oncologist
- Medical Oncologist
- Lung Cancer Nurse Specialist
- Thoracic Nurse
- MDT Co-ordinator
- Adjuvant chemotherapy patient navigator

To provide the most effective service will require development of a dedicated EPR form to capture all relevant details of the MDT including pathology results, need for adjuvant treatment, post-operative issues and future care needs. This document would form the cornerstone of communications between all teams involved in the patient's care.

Every patient that has undergone thoracic surgery will be discussed at this MDT. Patients will be listed 4 weeks after their operation and be appointed to a thoracic surgery clinic in the 7 days following the MDT. In this way, both surgeons and patients will have the benefit of this MDT discussion during the outpatient consultation. The oncologists will also have the benefit of a full MDT discussion when new patients are seen in their clinic for adjuvant treatment.

**Figure 1:** Pathway for the post-surgical care after lung cancer resection



### Investment requirements

Investment	Description	Cost per annum
Chest Physician Time, including MDT QA lead	0.5x PA – Can be incorporated into job plan during POU week	£0
Thoracic Surgery Time	0.5x PA – Can be supported by current team & incorporated into job plan	£0
Thoracic Radiology Time	1.5x PAs – including 1x PA of MDT preparation time	£21,420
Thoracic Pathology Time	1.5x PAs – including 1x PA of MDT preparation time	£21,420
Clinical Oncology Time	1x PA – includes post-MDT actions & appointments	£14,280
Medical Oncology Time	1x PA – includes post-MDT actions & appointments	£14,280
Lung CNS Time	0.5x PA – Can be supported by current team & incorporated into job plan	£0
Thoracic Nursing	0.5x PA – Can be supported by current team & incorporated into job plan	£0
MDT Co-ordinator Time	0.5x PA – Can be supported by current team & incorporated into job plan	£0
WTE Adjuvant chemotherapy patient navigator	Support entire pathway for adjuvant chemotherapy patients	£30,754
<b>Total</b>		<b>£71,400</b>

## Expected benefits of the business case

This business case will have a number of benefits:

- **Maximising uptake of adjuvant chemotherapy and monitoring adherence rates prospectively in line with National Lung cancer GIRFT recommendations**
- Improved patient experience and maximal efficiency of outpatient clinics - patients attending the surgical follow up clinic post MDT can have clear information about pathological findings and subsequent plans re adjuvant referral.
- Early adjuvant treatment decisions and timely referral to the appropriate oncology team
- Prevention of unnecessary oncology outpatient appointments
- Robust post-surgical pathway for all patients and ensuring robust care for all patients
- Standardised electronic documentation and a dedicated communication document to be sent back to the referring team post MDT – improved communication with referring trusts.
- A quality assurance review for the surgical service – all surgical resections will undergo review against international quality standards in thoracic surgery. Performance monitoring drives service improvements & will ensure quality care
- A robust mechanism to ensure any post-operative issues are highlighted and summarised for the benefit of surgical team, CNS and local CNS team (and physicians).
- Provision of LNC-PATH score and therefore recommended surveillance protocol (standardised risk stratified follow-up protocol for Greater Manchester).
- Robust mechanism to highlight further diagnostics - e.g. where synchronous disease identified at the outset and progression to 2nd treatment required
- Release of staff time – nursing time normally spent reviewing pathology results, completing adjuvant proformas and phoning patients.
- Release of MDT time – removal of adjuvant treatment cases and thoracic surgery radiology review cases from the lung cancer treatment MDT supports expansion of screening programme

This case is supported by the Greater Manchester Cancer Lung Pathway Board and supportive testimony has been provided by clinicians in the region:

### **Seamus Grundy – Chest Physician & Lead Lung cancer Clinicians, Salford Royal Hospital**

*I am fully supportive of this approach. At Salford we have had a number of occasions when written communication from the surgical centre has 'got lost' on its way to us which has led to delays in follow up and potential missed opportunities for timely surveillance. We also often find ourselves being asked questions from patients about issues we are unaware of due to limited or untimely communication from the surgical centre. A standardised, clearly communicated plan for both adjuvant treatment and post-operative surveillance would significantly improve the patient experience and quality of survivorship care across the region.*

## Appendix 1 - GM strategy for promoting earlier diagnosis & better outcomes in symptomatic lung cancer: getting the front end of the pathway right



GM NLCA-GIRFT  
Review & Action Plan

## Appendix 2 - GM strategy for delivering an accelerated lung cancer diagnostic & staging lung cancer pathway



GM NLCA-GIRFT  
Review & Action Plan

## Appendix 3 - GMMMG Medical Management of Tobacco Dependency Protocol



GM NLCA-GIRFT  
Review & Action Plan

## Appendix 4 - GM One-stop lung cancer clinic overview & process map



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Review & Action Plan

## Appendix 5 - GM Emergency Pathways in Lung Cancer



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## Appendix 6 - GM EBUS Single Queue Pilot Evaluation



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## Appendix 7 - GM Reflex testing in NSCLC Protocol



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## Appendix 8 - GM NSCLC N2 Trimodality Protocol



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## Appendix 9 - LNC-PATH protocol for risk stratified follow-up after curative intent treatment for lung cancer in GM



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Appendix 10 - ASSENT & STEPS protocol for risk stratified follow-up after curative intent radiotherapy for lung cancer



GM NLCA-GIRFT  
Review & Action Plan

<b>Title of paper:</b>	GM Cancer Pathway Boards Update
<b>Purpose of the paper:</b>	To update the GM Cancer Board on the leadership and work programmes of the pathway boards
<b>Summary outline of main points / highlights / issues</b>	<ul style="list-style-type: none"> <li>• Primary responsibility of the Pathway Boards outlined</li> <li>• Imminent changes surrounding the leadership of the Pathway Boards</li> <li>• Development of Pathway Board work programmes</li> </ul>
<b>Author of paper and contact details</b>	<p><b>Name:</b> Alison Armstrong  <b>Title:</b> Associate Director, GM Cancer  <b>Email:</b> alison.armstrong7@nhs.net</p>



## 1 Background and Context

The primary responsibility of the pathway boards is to improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire, ensuring there is focus on reducing inequality and addressing variation across the system. This paper will aim to update the board on the leadership and work programmes of the pathway boards to ensure maximised effectiveness.

The following principles for cancer services in the context of an Integrated Care System were approved by the GM system in July 2021:

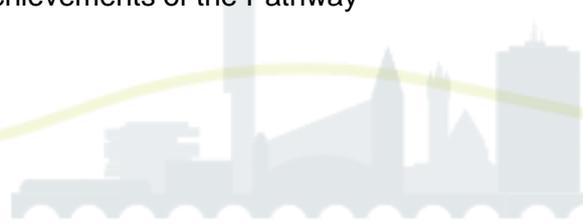
- Ensuring provider/commissioner cohesion through a single, shared planning and delivery 'entity' operating at a GM system level - an aligned cancer planning function and provider collaborative. Where reference is made to 'provider' this refers to all providers and not just secondary / tertiary care
- Taking a clinical pathway approach to planning from prevention through to personalised follow-up care - Clinical engagement and leadership from across the clinical pathway is essential to design, decision making AND delivery
- Ensuring delivery of National Cancer Programme, planning guidance and Long Term Plan expectations - core offer required across GM - Addressing unwarranted inequalities and variation in respect of access, quality and outcomes across GM and across pathways
- Including identifying and addressing challenges with delivery of national CWT standards
- Provider, commissioner, 3rd sector and Local Authority engagement is essential to design and delivery - Partnerships are key - between statutory partners, VCSE partners and service users

In addition, the NHS Cancer Programme is developing guidance to articulate the Cancer Alliance role in the future ICS landscape and as part of this work, plan to incorporate case studies illustrating the vital role Cancer Alliances play, and outlining the importance of how successfully established sub-specialist clinical panels has been central to delivering cancer transformation.

In July 2019, a paper entitled 'Greater Manchester Cancer Pathway Board Leadership update' was presented at Cancer Board to with an ask of support for the leadership review proposals to ensure that the clinical boards continue to be highly relevant and at the forefront of GM Cancer's enterprise. This paper is a subsequent update following implementation of the proposals agreed in that paper and providing a current position on Pathway Board leadership and programmes of work.

## 2. Clinical Lead Appraisal

In November/December 2021, all fifteen Pathway Clinical Leads in post for more than 12 months have had their annual appraisal. This forum gave an opportunity to formally acknowledge an incredibly difficult 18 months with the challenges of a global pandemic and recognise the value of the Clinical Leads' support and leadership. The sessions were chaired by Professor David Shackley (Director of GM Cancer and Senior Responsible Officer) and included representation from the GM Cancer Senior Management Team, commissioning, pathway management and GM Cancer service users. Each of the Clinical Leads were asked to deliver a presentation highlighting the achievements of the Pathway



Board under their leadership over the preceding twelve/eighteen months and suggesting a work plan for the forthcoming year with risks/deliverables and objectives articulated.

The tracking of progress in relation to the workplans will continue via the individual Boards but in addition, through Pathway Manager attendance at GM Cancer Programme Assurance Group where they are given the opportunity to present on the achievements and challenges of the Pathway Boards. Additionally, any ad-hoc 'hot topics' of major impact included on the agenda of the Senior Management Team weekly meetings.

### 3. Clinical Lead Recruitment

Due to the length of time the existing Clinical Leads have been in post, six Pathway Clinical Lead positions (as below) will be advertised imminently, with an open appointments process, retaining the existing arrangements of a 3-year term with the funding of the Pathway Clinical Lead PA being split equally between GM Cancer and the appointee's host Trust (0.5PA each).

Roles to be re-advertised in Q4 21/22
Clinical Lead for HPB Cancers
Clinical Lead for Lung Cancer
Clinical Lead for Psych-oncology
Clinical Lead for Palliative care
Clinical Lead for Haem-Onc Cancers
Clinical Lead for Head and Neck Cancers

### 4. Next steps

Once the proposed work programmes for the next 12 months are confirmed and aligned with the recently issued 2022/23 Planning Guidance, and agreed by the Pathway Boards, an overarching programme of work for the GM Cancer Pathway Boards will be developed and shared.

Recruitment to the Clinical Leads detailed above will be progressed.

### 5. Recommendation, requests / support required of the Board

Cancer Board are asked to note the content of this report are requested to approve the next steps outlined.



## GM Cancer Board March 2022

<b>Title of paper:</b>	Lynch Syndrome Testing & Compliance in Greater Manchester
<b>Purpose of the paper:</b>	To advise the board of issues surrounding Lynch syndrome testing compliance for colorectal & endometrial cancer in GM.
<b>Summary outline of main points / highlights / issues</b>	<ul style="list-style-type: none"> <li>• Background to Lynch syndrome testing</li> <li>• Compliance to NICE guidance in Greater Manchester</li> <li>• Funding implications for pathology</li> </ul>
<b>Consulted</b>	<ul style="list-style-type: none"> <li>• NW GMSA regional Lynch Syndrome Subgroup</li> <li>• Regional pathologists Lynch Subgroup</li> <li>• Nadia Ali-Ross – Clinical Lead Gynae Cancer GM Cancer</li> <li>• Sajal Rai – Clinical Lead Colorectal Cancer GM Cancer</li> <li>• Alison Jones – Interim Director of Commissioning - Cancer Services, GM Joint Commissioning</li> </ul>
<b>Author of paper and contact details</b>	<p><b>Name: Michelle Leach</b>  <b>Title: Pathway Manager, Greater Manchester Cancer Alliance</b>  <b>Email: <a href="mailto:Michelle.leach1@nhs.net">Michelle.leach1@nhs.net</a></b></p>



## 1 Background and Context

Each year, 1,100 colorectal cancers are caused by Lynch syndrome, making it the most common form of hereditary colorectal cancer. Lynch syndrome is an inherited genetic condition. It is caused by a germline pathogenic variant in one of four DNA mismatch repair (MMR) genes: MLH1, MSH2, MSH6 and PMS2. Pathogenic variants in another non MMR gene, known as EPCAM, can also cause Lynch syndrome.

NICE guidance DG27 – Molecular testing strategies for Lynch strategies in people with colorectal cancer, was published in February 2017. The guidance states anyone with a colorectal cancer diagnosis should be tested for Lynch syndrome. In October 2020 DG42 - Testing strategies for Lynch syndrome in people with endometrial cancer was published, the guidance states that anyone with a diagnosis of endometrial cancer should be tested for Lynch syndrome.

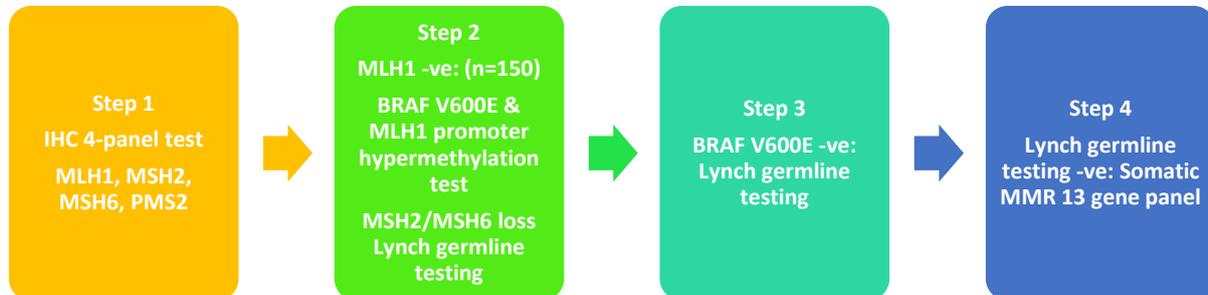
Testing colorectal & endometrial cancer patients for Lynch syndrome will meet the following national and regional priorities:

National / Regional Guidance	Description	Meeting priority in Manchester by:
Operational Planning Guidance 20/21	All providers should work with their designated Genomic Laboratory Hub to implement the national genomic test directory, the patient choice offer and fresh-frozen pathways	Testing for Lynch Syndrome is included in the national genomic test directory
NHS Long Term Plan 2019	Diagnose 75% of cancers at stage 1 or 2 by 2028	Relatives of Lynch positive patients will have regular surveillance and cancer will be diagnosed early
NHS Long Term Plan 2019	Secure our place at the cutting edge of research, offering genomic testing to all cancer patients who would benefit, and speeding up the adoption of new, effective tests and treatments	Testing for Lynch Syndrome and identification of affected relatives will ensure surveillance and timely diagnosis and targeted treatment

A [handbook](#) developed by the NHS Cancer Programme has been published for implementing Lynch testing and surveillance. The handbook outlines best practice in detection of these cancers at the earliest opportunity and prevention of these cancers through risk reduction treatments and surveillance.



### Steps in the immunohistochemistry testing strategy:



Testing for Lynch syndrome in endometrial cancer must be completed via Immuno-Histo-Chemistry (IHC), however, colorectal cancers can be tested via IHC or MMR (DNA Mismatch Repair) by PCR (Polymerase Chain Reaction). The IHC test is performed in local pathology laboratories and funded through their block contract, however, the PCR test is sent to the North West Genomic Laboratory Hub (NW GLH). The National Genomic Test Directory specifies which genomic tests are commissioned by the NHS in England, the technology by which they are available, and the patients who will be eligible to access to a test. The North West Genomic Laboratory Hub is responsible for delivering the tests within the directory for Greater Manchester. No additional funding has been provided to local Trusts to deliver testing for all colorectal cancer diagnoses, and therefore, although clinically the preferred method of initial testing for Lynch syndrome is IHC, financial and capacity pressures may drive the preference to utilise PCR testing, which therefore adds pressure to the NW GLH.

Manchester University NHS Foundation Trust (MRI) and The Northern Care Alliance (Salford) have the capability to perform the staining element of the IHC test, however, they do not currently have the capacity and have stated that they will require further funding for resource and equipment in order to deliver this for all colorectal cancer diagnoses across GM. The NW GMSA regional Lynch Syndrome Subgroup agreed that if those two pathology laboratories were able to provide the staining element to the process that the local laboratories could perform the reporting. This again would require further resource and training for pathologists.

## 2 NHS Planning Guidance 2022-23

The NHS Operational Planning Guidance for 2022-23 was released on 24/12/2021. This guidance states that systems are asked to work with Cancer Alliances to develop and implement a plan to make progress against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower. Within this guidance is the following specific reference to targeted case finding and surveillance, including:

Ensuring that every person diagnosed with colorectal and endometrial cancer is tested for Lynch syndrome (with cascade testing offered to family members), and patients who qualify for liver surveillance under National Institute for Health and Care Excellence (NICE) guidance are identified and invited to surveillance.

### 3 Current position / compliance in Greater Manchester

**Colorectal Cancer:** In Greater Manchester (GM) only one Trust Bolton NHS FT is fully compliant in testing colorectal cancer patients for Lynch syndrome via an SLA with Manchester University NHS FT, with the rest of the system currently testing for Lynch syndrome in people considered to be at high risk of this condition. Risk factors include family history of cancer or diagnosis at age 50 years or younger. Expanding testing to all patients with colorectal cancer will increase the detection of Lynch syndrome and, because Lynch is an inherited condition, identify families who could benefit from cascade genetic testing to determine if other family members are affected. This would lead to improved surveillance and consequently improved patient outcomes through prevention, earlier diagnosis and treatment if cancer is detected. Identification of patients with defective MMR proteins will also allow for directed therapies and personalised medicine.

**Endometrial Cancer:** GM is compliant for testing for Lynch syndrome in people with endometrial cancer, however, there is an increased pressure on pathology in the region in the team at Manchester Royal Infirmary who have been leading this work. Some Trusts are sending samples to Birmingham and Stoke for processing which can mean longer turnaround times.

### 4 Funding & Implications for Pathology

The major impact on implementing this guidance will be on pathology as they are responsible for the initial tumour testing. There will then be a subsequent impact on genetic testing and clinical genetics services, for which NHS England Specialist Commissioning team is the responsible purchaser. Delivering the overall NICE guidance requires a joined-up approach between pathology and genetic testing, as well as providers, CCGs, and commissioners (including specialised commissioning). As this arrangement is still to be determined we are not delivering against the NICE guidance and recommendations. Long term delivery of IHC testing is of concern without appropriate funding to the pathology labs within each Trust in GM. Each test takes an extra 5-10 mins of pathologist's time to look at the samples and the cost of consumables is increasing substantially. It is also thought that further tumour groups will be added i.e. stomach, HPB, brain & skin cancers in the future.

### 5 Next steps

#### Short Term Plan

GM has been allocated £77,000 by NHSE which is to be spent within the 2021/22 financial year to facilitate compliance to NICE guidance. The funds will be allocated based on incidence between February 2020 and February 2022 of colorectal and endometrial cancer. This will be accompanied with a memorandum of understanding that the allocated funds are intended to support universal Lynch screening by DNA mismatch repair immunohistochemistry (MMR IHC) in patients newly diagnosed with endometrial & colorectal cancer, as per the recommendations of NICE Diagnostic Guidance. The spend is outlined in the following table:



Trust	Total Incidence	Colorectal Average	Endometrial Average	Total Average	% of £77k Spend
Bolton	3,151	14.7	2.3	17	£9,548
MFT	5,913	22.8	4.4	27.2	£15,246
NCA inc Pennine	7,361	38.8	6.3	45.1	£25,256
Stockport	2,480	16.8	2.4	19.2	£10,780
Tameside	2,276	11.2	1.3	12.5	£7,007
WWL	3,401	13.7	2.6	16.3	£9,163
<b>Total</b>	<b>24,582</b>	<b>118</b>	<b>19.3</b>	<b>137.3</b>	<b>£77,000</b>

## Future Plan

The Lower GI cancer pathways were escalated and presented to Provider Federation Board on 26.11.21. This included the volume of patients on PTLs awaiting diagnostics and treatment, the diagnostic pathway, screening and the screening backlog so there are multiple problems within this pathway lynch compliance being only one of them. Whilst those problems need to be the immediate concern the following needs to be considered for the future:

- Upskilling workforce (working with GMSA and national group for education)
- Capacity planning (equipment and resource in local labs)
- Continue to engage clinical community re endometrial and colorectal lynch pathways
- Utilise the resources from the national team to create a toolkit and publish this to the Alliance website
- Feed into any larger pieces of work on pathology/genomic services reviews

## 6 Recommendation, requests and support required of the Board

- Re-patriate endometrial cancer IHC testing where outsourced
- Building on the work already completed by the Cancer Alliance, undertake a detailed review of the current and required capacity for GM pathology laboratories to undertake Lynch testing and therefore ensure GM compliance against the NICE guidance and national planning guidance
- Request that the GM Provider Federation Board, working on behalf of the GM Cancer Alliance Colorectal and Gynae Pathway Boards undertake the above review of all providers in GM
- As a result of the above, identify a clear equipment and training plan / resource requirement with a detailed implementation plan to be presented back to the GM Cancer Board by GM PFB
- CNS support for consenting patients



## Cancer board Paper

<b>Title of paper:</b>	Greater Manchester and East Cheshire Cancer Education update
<b>Purpose of the paper:</b>	This paper presents a progress update on training and education for the Cancer Workforce
<b>Summary outline of main points / highlights / issues</b>	<ul style="list-style-type: none"> <li>• Workforce and Education merger</li> <li>• Key highlights from 2021/22</li> <li>• Future plans for 2022/23</li> </ul>
<b>Consulted</b>	The content of this paper has been informed by the Associate Director for the School of Oncology and shared with the GM Cancer SMT for approval.
<b>Author of paper and contact details</b>	<p><b>Name:</b> Suzanne Lilley  <b>Title:</b> Programme Director for Workforce and Education, GM Cancer  <b>Email:</b> <a href="mailto:Suzanne.lilley2@nhs.uk">Suzanne.lilley2@nhs.uk</a></p>



## 1 Background and Context

The Greater Manchester (GM) Cancer Education Transformation Programme was established in April 2019 to March 2021, to improve access to high quality education for the cancer care workforce, across the health and social care system and thereby improve patient experience. Key areas of focus were:

- **Delivery of pathway and transformation programme events**
- **Delivery of a core GM Education programme** with a focus initially on three key educational areas - advanced communication skills, psychological 'Level 2'; and assessment and training for our MDT, cancer navigator and cancer support worker workforce.
- **Improving equality of access through communication about opportunities**
- **Bringing the cancer community together through delivery of GM Conference Events.**

To compliment the Education Transformation programme, the GM Workforce Lead established a system-wide steering group to support the development of a GM and East Cheshire (GMEC) Cancer workforce strategy and implementation plan, both signed off by the Cancer Board in 2021. The strategy is a five year strategy focusing on workforce transformation in line with the Health Education England (HEE) STAR workforce tool – upskilling, supply, new ways and working, new roles and leadership. It is impossible to achieve workforce transformation and redesign without focusing on training and education, and indeed the current strategy has training and education running throughout.

GM Cancer Alliance proposed the merger of the Education Board with the Workforce Steering Group to establish a Joint Cancer Workforce and Education Board, which had its inaugural meeting in January 2022.

The GMEC Cancer workforce and education board has three core functions:

1. To provide oversight and challenge to ensure the delivery of the cancer workforce implementation plan
2. To support organisations to embrace lifelong learning for all cancer health and care professionals
3. To act as a central forum for receiving and addressing system-wide workforce and education issues.

To ensure there is a forum to be responsive to specific system-wide training and education needs, an Education subgroup has been established which will feed into the board as per the structure below.





The agreed initial areas of focus for the education group are described in section 3 below.

## 2 Key discussion points

Title Key highlights from 2021/22	
<b>Subject</b>	<p><b>GM Cancer Academy</b></p> <p>Funding was awarded to pilot the first cancer academy in Greater Manchester, which is currently being piloted in the urology pathway. The academy aims to develop a sustainable lifelong learning model for the non-medical cancer workforce designed to meet the current and future needs of the population. It is working in collaboration with GM Higher Education Institutions to pilot a suite of educational offerings to inform the academy model. The longer term aspiration is to refine an academy model which can be adapted and adopted by other cancer pathways.</p> <p><b>Aspirant Cancer Career Education Development Programme (ACCEND)</b></p> <p>The ACCEND programme is a collaboration between Health Education England, Macmillan, UKONs, Royal College of Nursing and GM Cancer Alliance to support the recruitment and retention of Cancer Clinical Nurse Specialists in line with the National People Plan. This evolved from the North West CNS capability framework project funded by HEE in 2021, led by GM Cancer Alliance. The overall purpose of the ACCEND programme is to provide guidance and direction on the knowledge, skills and capabilities required by all nurses and allied health professionals who care for people affected by cancer in generalist and specialist cancer services and roles as part of multi-professional teams across the four UK nations. GM Cancer Alliance is leading the CNS element of this career and education programme.</p> <p><b>Health Education England (HEE) Cancer Nursing Grants</b></p> <p>40 Cancer CNS and 10 chemotherapy nurses across GM were offered training grants from HEE to upskill in areas where there was an identified need. GM Cancer alliance helped to coordinate this to ensure equity of access.</p>

### **Cancer Support Worker training and education programme**

At the end of 2020-21, underspend from the education transformation programme, created by the COVID pandemic, was used to commission a core programme of education. This included a GM training programme for Cancer support workers, (Navigators, Cancer care coordinators) and MDT coordinators, which is currently take place.

To build on the work initially started through the Education Transformation programme and ensure GM has a sustainable training programme, funding was secured through HEE to develop and pilot a training and education framework in the North West. The project has now evolved into a national programme. GM Cancer is working in collaboration with Cheshire and Merseyside and Lancs and South Cumbria alliances to develop a standardised career and education programme for Cancer Support Workers and will be one of the first to pilot this programme with nine cancer support workers across Greater Manchester.

### **North West Endoscopy Academy**

The GM workforce team worked in collaboration with NW alliances to develop an academy model to secure funding from HEE and NSHE/I. The academy will support training and education for the whole of the endoscopy workforce including admin and clerical, decontamination staff and endoscopy navigators. The model will be a hub and spoke model with the MRI being the initial spoke for GM.

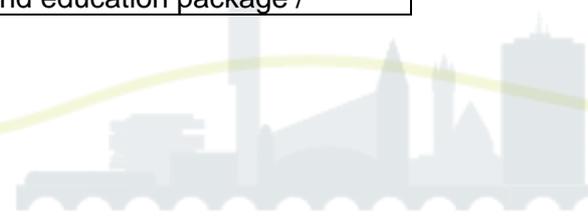
### **Psychological education and training for the cancer workforce**

Utilising education transformation underspend, a number of training courses were delivered to the GM CNS workforce to upskill in advanced communications and Psychological level 2.

In addition to this, the alliance funded 4 psychological level 1 training days for cancer support workers and worked with Health Education England to pilot the first Making Every Contact Count (MECC) for Cancer course available to a wide range of staff including admin and clerical staff, and healthcare assistants. The MECC for cancer course has been designed in collaboration with key stakeholders across GM as a means of training staff in recognising and acknowledging the concerns of patients, many of whom have had diagnoses delayed and treatments disrupted. MECC for cancer allows for large numbers of frontline staff to feel confident in responding appropriately to expressions of low-level distress and prevents cancer patients presenting later with chronic unmet psychological need.

### **Acute Oncology workforce**

The GM Acute Oncology (AO) pathway board has been leading the development of an AO competency framework and education package /



workbook. This work has received attention nationally and has evolved into a nationally funded piece of work to design and develop an AO Passport following a similar structure and methodology to the UKONS Systemic Anti-cancer Therapy Competence Assessment Passport.

### **Primary Care & Early Diagnosis / Gateway C**

In 2021/22 the GM Cancer Early Diagnosis programme commissioned GatewayC to develop a programme of work aimed at increasing engagement with the early detection agenda in the GM Primary care arena. This programme of work was designed in line with the steer from the GM Primary Care Cell.

To date: GatewayC has delivered

- 10 GM webinars involving GM Cancer Pathway Board Clinical Leads and accessed by over 400 primary care staff live and 200 on demand
- Lower GI; Lung; Prostate; Upper GI; Skin; Breast; HPB; Symptom recognition; Head & Neck, Faecal Immunochemical Testing (FIT)
- Production of 10 x infographics summarising the learning
- Production of 10 x 5-8 minutes 'Fast Facts' videocasts to deliver a summary of the information from the webinar.

### **School of Oncology**

The School offers a portfolio of cancer training and events which is available to all staff in GM. Despite the restrictions of COVID, over the last 12 months there have been:

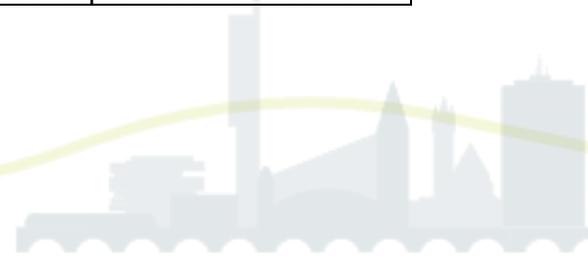
- 61 half or full day Cancer Educational Events,
- Academic MSc level cancer qualifications run jointly with the University of Manchester
- Maguire advanced, enhanced and basic level communication, leadership and management skills and teacher training,
- A suite of learning for all staff involved in PET-CT delivery, including development of the radiology and radiographer workforce and many other online training opportunities, all available to our GM workforce.

5000+ people have accessed the 100+ opportunities available from the School. Currently approximately 45-50% of these are from GM

Additional in 2021, the School of Oncology has supported the development of 8 x GM specifically commissioned events. This has included the two major GM system cancer events (world cancer day and the virtual cancer week) as well as events delivered by the psychological pathway, the OG pathway and the Breast pathway.



Title Future plans for 2022/23	
<b>Subject</b>	<p><b>GM Education subgroup</b></p> <p>The initial areas of focus will be as follows:</p> <ul style="list-style-type: none"> <li>• Mapping of Greater Manchester cancer-specific educational offers to identify gaps</li> <li>• Developing and promoting a directory of cancer educational offers</li> <li>• Defining priority areas for funding</li> <li>• Providing oversight for the GM Annual Cancer event / conference</li> <li>• Defining / promoting The Christie School of Oncology 'offer' to the Greater Manchester cancer workforce</li> <li>• Defining / promoting the Gateway C 'offer' to the Greater Manchester cancer workforce</li> <li>• Strengthening links between the three core cancer-specific GM based education providers: The GM Cancer Academy, The Christie School of Oncology, and Gateway C</li> <li>• Improving links with relevant student populations to promote a career in cancer</li> <li>• Developing a cancer education offer to key GM Cancer leaders such as Pathway Board Directors, Clinical Leads, and Cancer Managers in the first instance</li> <li>• Reviewing requests for education events / webinars / training from pathway boards and if appropriate supporting the delivery of agreed educational offers</li> <li>• Supporting the development and implementation of a Psychology training framework for the whole of the cancer workforce</li> <li>• Supporting the development of a training programme for service user representatives / staff working with service users</li> <li>• Exploring the development of a GM Cancer Volunteer training programme</li> <li>• Exploring methods of measuring the effectiveness of existing / future training and education programmes.</li> </ul> <p><b>Primary Care &amp; Early Diagnosis / Gateway C</b></p> <ul style="list-style-type: none"> <li>• An ongoing programme of Gateway C Live GM webinars has been commissioned and the plan is to continue this into 2022-23</li> <li>• Develop content for a further 3 pathways / topics: Non-Site-Specific Symptoms; Gynaecological Cancers; Health Inequalities</li> <li>• On-going work on the in-depth analysis of uptake impact across the region</li> <li>• Ongoing targeting of hard to reach groups and promotion of webinars</li> </ul>



- Development of some face to face learning for specific groups

The GM cancer leads for primary care and early diagnosis will work with the workforce and education team to further develop the education offer to primary care professionals to support the ongoing early diagnosis and cancer recovery programme of work in 2022-23.

### **Allied Health Professionals (AHPs) cancer training and education programme**

The NW AHP survey findings conducted by the alliance in 2021, identified a gap in cancer-related training specifically for generalist AHPs working in the community. As a result of this work, the alliance has secured £1.2 million from the Greater Manchester Combined Authority to develop and pilot a cancer-specific training programme to upskill 1200 generalist and specialist AHPs.

### **School of Oncology**

The school specialises in developing partnerships to ensure optimal delivery of cancer education. It will support the GM workforce through multiple opportunities developed with partners across the system there will include:

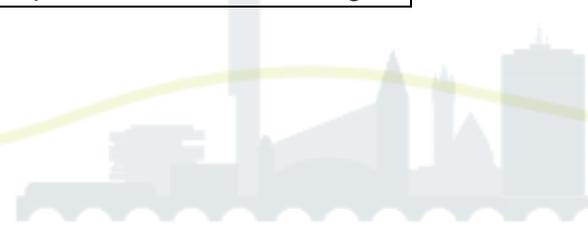
- GM Cancer commissioned courses and pathways events
- Supporting the GM Cancer Urology Academy
- The School events portfolio
- The Christie Surgical Skills Programme
- The Christie Proton School
- Christie & University of Manchester Academic Programmed of study
- The Manchester Cancer Research Centre Academic Cancer Programme

### **GM Aspirant Nurses programme**

A development programme has been created by the Lead Cancer Nurse at Tameside targeting the generalist nursing workforce who have an interest in working in cancer services / nurses aspiring to be a CNS. The programme offers a combination of formal training and placement opportunities. Five trusts across GM are piloting the programme using funding from HEE in the hope that this will increase the future supply for the CNS workforce.

### **GM Cancer Academy**

The cancer academy has received further funding to continue until March 2023. This will enable piloting of the newly developed materials and testing



	<p>the effectiveness of the variety of offerings. It will also enable further cancer pathways to test the model. Discussions are already progressing with the Acute Oncology pathway board regarding this.</p> <p><b>Equality, Diversity, and Inclusion workforce project</b></p> <p>The Christie was awarded funding from the GM Workforce Collaborative to develop a model of Equality, Diversity, and Inclusion (EDI) training and professional development, based on the cancer care pathway. The project aims to create a cancer pathway led EDI education programme for cancer care professionals across Greater Manchester. The programme will address the EDI needs of the cancer patient, using the principles of intersectionality and protected characteristics, by equipping the professional with enhanced skills to identify and meet the patient's needs.</p> <p>The project intends to work with established MDTs across the system to gain traction and plan sustainable solutions. A complementary programme will be designed to improve the equality of appointing minority groups from interview, addressing the second indicator of the Workforce Race Equality Standard, a priority of the NHS People Plan. This project will feed into the GM Cancer workforce inequalities subgroup.</p> <p><b>Pharmacy upskilling project</b></p> <p>HEE has funded a chemotherapy focussed pharmacy workforce development project led by The Christie. The project will aim to upskill pharmacy professionals in understanding the chemotherapy services context to improve integration of clinical and specialist technical knowledge to improve service, freeing up nursing time and improving accessibility to services for patients. The full scope of the project is currently being scoped and will feed into the Workforce and Education Board.</p>
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### 3 Summary

It is important to acknowledge that the above activity is not a comprehensive list, as there is a vast amount of work taking place across Greater Manchester to develop training that will benefit the cancer workforce beyond the work of the three core education-specific providers (SoO, GatewayC, Cancer Academy). One example is the Greater Manchester & Eastern Cheshire Strategic Clinical Network in Partnership with Greater Manchester Cancer Palliative and End of Life Care Advisory Group, which has established a GM Educators network overseeing palliative care and end of life education across Greater Manchester.

The activity highlighted in this paper is a snapshot of some of the exciting developments that have taken place during the pandemic. It also highlights the breadth of training and education in progress or planned for 2022/23 to help achieve one of the Workforce and Education Board's key objectives to enable lifelong learning for all cancer health and care professionals. Our cancer workforce in Greater Manchester needs this investment more



than ever in order to retain staff following two of the most difficult years the NHS has ever had to endure. A more detailed progress report on delivery of the Cancer Workforce and Education strategy implementation plan will be presented at the next Cancer Board.

#### **4 Recommendation, requests / support required of the Board**

The Greater Manchester Cancer Board is asked to note progress made to date with cancer education and future plans to invest in our cancer workforce.

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