GM Cancer – Cancer Board Agenda

Meeting time and date: Monday 10th October 2022, 3pm-5pm.
Venue: The Life Centre 235 Washway Rd, Sale M33 4BP
Meeting Chair: Roger Spencer, Co Chair: Anita Rolfe.

	Item	Type	To	Lead	Time
1	Welcome and apologies Minutes from the previous meeting, 25th July Action log and matters arising.	Verbal Paper 1, Pg.2 Paper 1 Pg.11	- Approve Update	Roger Spencer Anita Rolfe	5’
2	Cancer Board Terms of Reference	Paper, Pg. 12	Approve	David Shackley	10’
3	Early Diagnosis	Presentation 1, Pg. 15	Update	Sarah Taylor	15’
4	Faster Diagnosis & Operational Improvement and Treatment	Presentation 2, Separate attachment	Update	Lisa Galligan-Dawson	15’
5	Single Queue Diagnostics - Business Case	Paper 2, Separate attachment	Approve	Lisa Galligan-Dawson	15’
6	Personalised Care	Presentation 3, Pg. 24	Update	Freya Howle	15’
7	Communications & Engagement	Presentation 4, Pg.33	Update	Anna Perkins	15’
8	Spotlight Section: - Complex One Stop Lung Clinic	Paper 3, Pg.41	Update	Matthew Evison & Lisa Galligan-Dawson	20’
9	Papers for Information: - Quarter 1 Planning Return - Risk Register - GM Targeted Lung Health Checks (TLHC) Programme Board Update	Paper 4, Separate attachment Paper 5, Separate attachment Paper 6, Separate attachment	 Update Update Update	 Alison Armstrong Alison Armstrong David Shackley	-
10	AOB	-	Discuss	All	10’

The next meeting is scheduled Monday 28th November 2022, 3pm-5pm at The Life Centre 235 Washway Rd, Sale M33 4BP

Greater Manchester Cancer Board
Minutes and Actions

Meeting time and date: Monday 25th July, 15:00pm-17:00pm
Venue: Virtually, via MS Teams

Members present			
Name	**Role**	**Organisation/ Representation**	**Attendance 2022/2023**
Anita Rolfe (AR)	GM Cancer Board Co-Chair	Stockport CCG	2/5
Dave Shackley (DS)	Director & Clinical Lead	GM Cancer	2/5
Claire O'Rourke (COR)	Managing Director	GM Cancer	2/5
Sarah Taylor (ST)	GP/ Primary Care Lead	GM Cancer	2/5
Lisa Galligan-Dawson (LGD)	Performance Director	GM Cancer	2/5
Suzanne Lilley (SL)	Cancer Workforce Lead	GM Cancer	2/5
Alison Jones (AJ)	Director of Cancer Commissioning & Early Diagnosis	GM Cancer / GM Joint Commissioning Team	2/5
Anna Perkins (AP)	Communications and Engagement Lead	GM Cancer	1/5
Rhidian Bramley (RB)	Diagnostics Project Clinical Lead	GM Cancer	2/5
Nabila Farooq (NF)	User Involvement Rep PaBC	GM Cancer	2/5
Leah Robins (LR)	Rep for GM Chief Operating Officers	Northern Care Alliance Group	1/5
Sarah Price (SP)	Chief Officer	GM Health & Social Care Partnership	1/5

In attendance		
Name	**Role**	**Organisation/Representation**
Beth Sharratt (BS)	Project Manager (Health and Social Care VCSE Engagement)	GMCVO
Caroline Davidson (CD)	Director of Strategy	Manchester Foundation NHS Trust
David Wright (DW)	TYA Lead Nurse & Clinical Lead for TYA	Manchester Foundation NHS Trust
Jemma Woodward (GWo)	Deputy Lead Cancer Nurse	Manchester University Foundation Trust
Janet Castogiovanni (JC)	Director of Performance	GM Health & Social Care Partnership
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
Professor Robert Bristow MD PhD (pRB)	Director	Manchester Cancer Research Centre
Richard Booton (RBo)	Clinical Director, Directorate of Lung Cancer & Thoracic Surgery	Manchester University Foundation Trust
Roger Prudham (RP)	Consultant Gastroenterologist / Lead Cancer Clinician	Northern Care Alliance NHS Group
Sadhbh Oliver (SO)	Senior Team Administrator	GM Cancer
Teresa Karran (TK)	Regional NHS Relationship Manager	CRUK
Tom Thornber (TT)	Director of Strategy	The Christie NHS Foundation Trust
Victoria Dickens (VD)	Director of AHPs	Northern Care Alliance NHS Group

Zoe Merchant	Programme Manager – Lung Health Check Programme	Manchester Foundation NHS Trust
GM Cancer Team Members	Alexandra Riley	GM Cancer
	Alison Foxley	GM Cancer
	Becky Cook	GM Cancer
	Jane Cronin	GM Cancer
	Jaqie Lavelle	GM Cancer
	Jess Docksey	GM Cancer
	Joseph Henshaw	GM Cancer
	Lauren Kelly	GM Cancer
	Louise Lawrence	GM Cancer
	Louise Retout	GM Cancer
	Paul Keeling	GM Cancer
	Philip Graham	GM Cancer
	Sarah Lyons	GM Cancer
	Sue Sykes	GM Cancer
	Stella Ruddick	GM Cancer
	Tara Schaaffe	GM Cancer

Apologies			
Name	**Role**	**Organisation**	**Attendance 2022/23**
Roger Spencer (RS)	Co-Chair / Chief Executive	The Christie Foundation NHS Trust	1/5
Alison Armstrong (AA)	Associate Director	GM Cancer	1/5

Cathy Heaven (CMH)	Programme Director of Cancer Education	The Christie NHS Foundation Trust	1/5
Rob Bellingham (RobB)	Managing Director	GM Joint Commissioning Team	1/5
Professor Janelle Yorke (JY)	Executive Chief Nurse & Director of Quality	The Christie NHS Foundation Trust	1/5
Susan Todd (ST)	Programme Director for Transformation	GM Cancer	1/5

1. Welcome and Apologies, Minutes of the last meeting & Action log and matters arising	
Discussion summary	DS gave welcomes and introductions and listed apologies for the meeting. The minutes from the March board were ratified and all open actions were reviewed. SO to update the action log accordingly.
Actions and responsibility	No action required.

2. Overview of the GM Health System	
Discussion summary	DS provided several updates relating to areas in the GM Health System. • David Thompson was successfully recruited to the role of Clinical Lead for Research. • DS noted that there had been limited updates surrounding the 10-year plan / war on cancer plan. However, publications were expected around September. It was recognised that the paper would be brought to the October board and updated upon if published in time. • It was recognised that the Integrated Care System went live on the 1st July. • The Targeted Lung Health Check programme had agreed in principle to roll out further in due course via a PCN based rather than locality-based approach. STa highlighted that the national screening committee was also considering it to possibly become a part of the formal national screening programme. NF noted the positive feedback that there had been from the user representatives in relation to model of care for lung and TLHC programme. AP provided an update on how the User Involvement review was progressing, nothing that it was in its final stage which consisted of 10-minute online survey. It was encouraged that any stakeholders who are engaged with the UI programme, as well as user representatives, complete the survey. Please find the link to the

	survey as follows: https://survey.euro.confirmit.com/wix/3/p148844003053.aspx?Sample=1 COR highlighted that the GM system was in a state of heightened escalation due to these increase staff absence levels following the most recent wave of covid. Feedback was provided from recent meetings including GM Gold Command. It was recognised that the emergency department and NWAS were facing pressure and suffering significant delays. 20% of patients in hospital were suffering with covid, hospital capacity sat at 96-98% in GM and no reason to reside figures sat at over a thousand. COR assured the board that members of GM Cancer Alliance were in regular attendance of Community Co-ordination Cell, Gold Command and PFB, and were championing what was going on from a cancer service perspective in GM services. It was recognised that whilst there had been growth in the cancer backlog since March, innovation work was still a focus of the alliance.
Actions and responsibility	No action required.

3. GM Cancer & ICB Update	
Discussion summary	The paper from the national cancer team, detailing the role of the cancer alliance in the new ICB was shared with the board membership ahead of the meeting. Please see the 'Improving cancer outcomes: guidance on how ICBs and Cancer Alliances will work together' paper for full details. COR noted the various elements of work that the alliance would lead on going forward in the ICB. With recognition that the alliance would have primary role in supporting system delivery of cancer improvement metrics and innovation, sharing best practice across the system, and supporting the system in achieving the aims outlined in the long-term plan and planning guidance. Emphasis was placed on the role that GM would continue to play in carrying out existing innovation and taking forward new clinical innovation. It was recognised that the GM Cancer – Cancer Board will be informing the system of where GM is as a whole from a cancer perspective, and how GM is performing against the planning guidance/ 10 year plan 3 Key areas were highlighted by TT in relation to the transition to the ICB.

	1. Connections had been put into place in the system and work was being undertaken being held to mitigate any challenges that could arise from transitioning to the ICB. Such as the ICB workshops. 2. Performance and the move to system oversight performance. 3. Strategic planning and looking into the delegation of specialist commissioning/ specialist services to ICB level that are currently the responsibility of NHSE. With the intention to delegate from April next year. With a primary aim around how reduce the demand expensive tertiary services and improve early detection. LS additionally noted that many specialised services run across multiple ICSs, with GM being a large importer of specialist service patients. AJ assured that a close working relationship would continue with the GM CCGs, with physical discussions planned with the CCG around how the new system will work. TT highlighted that the system would move from a cost-based model to a patient allocation model which will allow funding to flow with patients across regional borders. DS queried if the Cancer Board will be the new recommendation body who approves items which different groups need to be involved in? DS also highlighted that work could not be loo at from an isolationist GM viewpoint, and work needed to be linked in with the national and regional teams who could provide specific help and guidance.
Actions and responsibility	• SO to add the report on how small decisions are being commissioned appropriately in the new ICB to the next board. • GM Cancer to create a map that demonstrates how the different GM entities will fit together in the new ICB structure.

4. Model of Care for Lung	
Discussion summary	ME presented on the Model of Care for Lung. This document has been produced by the GM Cancer Lung Pathway Board and commissioners in GM and provides a clinical consensus from across the region for what the optimal care for symptomatic lung patients should be. Covering a variety of aspects relating to care. Please see the 'Model of care for lung' paper included in the board papers for specific details. It was recognised that the paper supports the earlier diagnosis agenda and the standardization of care to reduce inequalities. Enabling GM to look at unwarranted variation across the system. As well as providing a useful framework for services and hospitals to work against.

	<u>Work in relation to the Model of Care for Lung.</u> Individual areas of care had been asked to provide the small lung improvement group with a gap analysis to see where they are now against what the model of care strives to achieve. Results from which would provide an opportunity to see what the barriers are to achieving this. It is expected that results from the analysis would likely be ready to circulate in 3 months' time. <u>Reception of Paper</u> There was praise from the board over the papers inclusion of a GM strategic view and key strategic ambitions that sit across the system. Providing the alliance the alliance to see what work in GM will have the biggest impact on the wider system and can be categorised as a priority. It was also recongised that the paper provided an example of pathway led work in the new ICB, which TT noted was a prime example of how work in the GM system should continue to be formed moving forward. It was recognised that this paper had been signed off by the Directors of Commissioning and PFB, who provided their support and endorsement to deliver in the ways described in the paper. There was discussion around how this paper could be made to reach front line services directly rather than having leadership try to filter information down. STa noted that Primary Care would be in a good position to circulate wider messages relating to the Model of Care. AR highlighted that there were multiple avenues that enable information to get into system such as GM system quality group and Locality Quality Group, which every locality is required to have. RB also suggested that information could be cascaded in training that was already set up with frontline staff, such as the workshop being held for lead radiologists.
Actions and responsibility	▪ SO to add to the 'Model of Care for Lung' to a future board agenda to enable membership to see the changes that have occurred as a result of its publication. ▪ Model of Care for Lung presentation to be listed at the next GM Quality group.

4. Cancer Recovery & Performance Key Risks & Operational Improvement	
Discussion summary	The 'Cancer Operational Performance & Recovery' paper was shared in advance of the meeting for membership to review. The paper detailed the work going on in localities at a system level, provided a comprehensive overview of where GM are as a system in relation to cancer, GM trajectories, and the delivery requirements for the year. Please see the paper for further detail.

	LGD noted that there was a new responsibility, following the shift to the ICB, around supporting operational delivery and recovery. Which needed to be done through a pathway approach and working with partner organisations. Key areas performance. Please see the performance presentation slides for specific data figures. - It was recognised that referral rates remained elevated however work was being undertaken to try and ensure that correct referrals were entering the system. i.e. Dermatascope training and FIT testing. - It was recognised that GM had an increasing PTL. - The GM CWT performance had been affected by the NCA IT challenges which prohibited reporting. This in turn meant that accurate GM CWT figures would not be visible until 6 months' time. - There continued to be variation in the treatment for patients across the system based on locality. - Whilst the planning trajectory appeared to be achieved, LGD highlighted that there were several incomplete records which would likely change GM's performance status once complete. Key actions and Updates - It was recognised that the Complex One Stop Lung clinic went live in June 2022. ME reported how the clinic was progressing noting the success so far and reduction in the time taken for a decision to treat as a result of the clinic. - Work was being implemented around demand management and the appropriateness of referrals entering the system. - LGD noted that there had been an additional improvement focus in GM Gold, PFB, COOs and EMDs with extra steps of escalation being taken around performance trajectories. - A GM Cancer recovery panel had been set up and was hosting monthly pathway specific meetings to look at the recovery of pathways performance. Questions STa noted that they felt to improve the quality of referrals there needed to be better communication between primary and secondary care. STa asked if the board would support making communication regarding referrals between primary and secondary a priority across all the trusts in GM. TT queried how the current challenges in system would be managed as GM went into its winter months. LGD noted that winter was being brought forward by GM Gold, and a GM cancer improvement week was to be held which intends to scope out challenges and ahead of the curve. LGD also felt that the system needed to improve its surgery recovery numbers, with six-week surgical treatment averages

	sitting at around 250 per week when they would need to sit at 310 per week. It was also felt that targeted work needed to continue such as single queue that would drive performance improvement.
Actions and responsibility	SO to add a 'Complex One Stop Lung Clinic' update to October Board agenda.

6. Papers for Information: GM Cancer Pathway Board Work Programmes update Q1 22.23 GM Cancer Annual Report GM Cancer Conference & Awards	
Discussion summary	The GM Cancer 2 year annual report was approved by the board. AP provided details around the GM Cancer conference and the awards that are being created in conjunction with the conference. It was noted that the event will be hybrid and the themes of the conference would be equality, innovation, and collaboration. It was asked that members of the board let colleagues in the system know about the awards and ask all who would be interested to contribute.
Actions and responsibility	No action required.

10. AOB	
Discussion summary	It was noted that the next meeting would be held as a face to face event, with recognition that the structure of the agenda would be altered with a focus on prevention, operational performance and personalised care & treatment.
Actions and responsibility	No action required.

The next meeting is scheduled Monday 3rd October 2022, 3pm-5pm at The Life Centre 235 Washway Rd, Sale M33 4BP.

Action Log

Prepared for the 4th October GM Cancer Board

Log No.	AGREED ON	ACTION	STATUS
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.	**Update.** Awaiting reviewed copy back from the national team. To be circulated once released and circulated with the national published 10-year 'war on cancer' plan expected July 2022 (July or September board) Update 25.07.22 – No update yet provided from the national team. It was assured that once confirmed the plan will be circulated and updated at the nearest board.
30.21	March 2022	SO to circulate the GM Cancer Draft Annual Report alongside the minutes from the March Board minutes.	**Closed 25.07.22 –** Report circulated and approved by the board membership.
02.22	July 2022	Model of Care for Lung presentation to be listed at the next GM Quality group.	
03.22	July 2022	SO to add a 'Complex One Stop Lung Clinic' update to October Board agenda.	Closed - SO added to October agenda. ME & LGD to present.

Greater Manchester Cancer Board

Terms of Reference
September 2022 (version 6)

1. Aim of the board

The Greater Manchester (GM) Cancer Board aims to achieve world-class cancer outcomes and experience for the people of Greater Manchester by providing a robust mechanism for engaging systematically with wider stakeholders, including patients, the public and patient organisations.

The Greater Manchester Cancer Board will have oversight of the delivery of the cancer elements of the NHS Long Term Plan and annual operational planning guidance, with the aim of reducing inequalities and variation.

2. Role of the board

GM Cancer Board brings together senior representatives from its constituent organisations, with representatives covering the whole patient pathway. The board members should be able to make decisions on behalf of their organisations and be able to contribute actively to leading delivery of the Cancer Alliance plan.

To facilitate the Cancer Alliance role in leading whole-system planning and delivery of cancer care, it is important that there is a clearly defined relationship between the Cancer Alliance and ICB.

3. Accountability and decision-making

The GM Cancer Board will be accountable to NHS Greater Manchester Integrated Care and will report to GM Board meetings as required (*detail in development and TBC*).

The Cancer Alliance will provide a quarterly report on progress to NHS Greater Manchester Integrated Care and to NHS England and NHS Improvement (the latter through its Regional Director)

Governance and decision-making arrangements may change over time to reflect local circumstances.

4. Membership

The Greater Manchester cancer system is made up of a large number of organisations and bodies. The membership of the Greater Manchester Cancer Board reflects the full breadth of this system.

The Cancer Board will be chaired by a senior leader from one of the Alliance's constituent organisations and will include senior clinical and managerial representatives. The membership of the board is set out in the table below.

Co-Chairs:

- Chief Executive, The Christie NHS Foundation Trust
- GM Place lead representative: Stockport

- GM Finance representative
- NHS GM Integrated Care Medical Director
- NHS GM Integrated Care Chief Officer for Population Health & Inequalities
- Cancer Alliance Medical Director
- Cancer Alliance Managing Director
- Cancer Alliance Associate Medical Director
- NHS GM Integrated Care Director of Primary Care and Strategic Commissioning
- Head of Place-based Commissioning – Greater Manchester (Specialised Commissioning) NHS England and NHS Improvement – North West Region
- Managing Director, Greater Manchester Primary Care Provider Board
- Clinical Lead / Chair, Greater Manchester Primary Care Provider Board
- GM Cancer Associate Director
- GM Cancer Performance Director
- Director of Cancer Commissioning & Early Diagnosis, Cancer Alliance
- Managing Director, GM Provider Federation Board
- GM Trust Chief Operating Officer representative
- GM Trust Director of Strategy representative
- Patient representative(s)
- GM community and voluntary sector health organisation representative(s):
- Lead Cancer Nurse representative
- Allied Health Professional representative
- Population Health representative

- Research representative
- Lead Cancer Clinician representative
- Chief Nurse representative

Each group or organisation will be represented by a senior named individual who is committed to consistent attendance at board meetings. Members may nominate deputies but these should be of sufficient seniority to have delegated authority to act on the named member's behalf. Members and their deputies are representatives of both their own organisations and of colleagues elsewhere in the cancer system. They are responsible for engaging and consulting with wider colleagues on the work of the board.

The Board will invite expert representatives of the Alliance, other bodies or organisations as its agenda requires. Similarly, organisations or bodies may make a request to the Chair that they are directly represented at a particular meeting or agenda item.

5. Frequency of meetings

The Greater Manchester Cancer Board will meet on a bi-monthly basis.

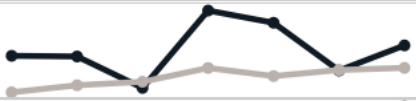
Early Diagnosis Programme Update

GM Cancer Board 10th October 2022

Dr Sarah Taylor Clinical Lead

Ali Jones, Programme Lead

Current Position: Early Diagnosis

Locality	Most Recent Period	Most Recent Performance	Most Recent Position	Comparators: Previous Period - Comparator Locality	Comparators: Locality - Comparator Locality	Comparators
GM	FY 2019	54.9%		+0.1% ▲ FY 2018: 54.8%	-0.4% ▼ National:55.3%	
Bolton	FY 2019	56.2%		+1.5% ▲ FY 2018: 54.7%	+1.3% ▲ GM 54.9%	
Bury	FY 2019	57.8%		+2.2% ▲ FY 2018: 55.6%	+2.9% ▲ GM 54.9%	
Rochdale	FY 2019	57.7%		+3.7% ▲ FY 2018: 54.1%	+2.8% ▲ GM 54.9%	
Manchester	FY 2019	53.9%		-0.8% ▼ FY 2018: 54.7%	-1.0% ▼ GM 54.9%	
Oldham	FY 2019	52.7%		-1.3% ▼ FY 2018: 54.1%	-2.1% ▼ GM 54.9%	
Salford	FY 2019	54.2%		+2.8% ▲ FY 2018: 51.4%	-0.7% ▼ GM 54.9%	
Stockport	FY 2019	55.1%		-0.9% ▼ FY 2018: 55.9%	+0.2% ▲ GM 54.9%	
Tameside	FY 2019	54.9%		-0.2% ▼ FY 2018: 55.0%	0% GM 54.9%	
Trafford	FY 2019	56.0%		-0.6% ▼ FY 2018: 56.5%	+1.1% ▲ GM 54.9%	
Wigan	FY 2019	52.6%		-2.3% ▼ FY 2018: 54.9%	-2.3% ▼ GM 54.9%	

Relationships

- **Early Diagnosis Steering Group**
- Engagement and Co-Production
- Clinical design and leadership
- National and NW teams (Cancer)
- GM Integrated Care Partnership
- Localities and PCNs
- Provider and Commissioner
- VCSE
- GM Cancer colleagues
- Alignment with GM programmes
- Locality visits – peer support

Greater Manchester Cancer

Key Updates/Successes – as per planning priorities

Delivery plan priority	Update
Getting people into the system: Timely presentation	Design and delivery of a programme of patient / public facing work with the GM comms team – financial investment.
Getting people into the system: Effective primary care pathways	Early diagnosis webinars ongoing. Links with Cancer Academy. Cancer Forum scheduled for 30th November 2022.
NHS Cancer Screening, targeted case finding and surveillance: NHS Cancer Screening	Cervix visualisation guides purchased and to be given out at training session early December – joint with screening team. Screening searches developed and to be rolled out by GM primary care DQ team
NHS Cancer Screening, targeted case finding and surveillance: TLHCs	3 projects operating. Roll out plan developed for 2023-24 at PCN level. Programme Board leading this – Co-Chair Prof Shackley
NHS Cancer Screening, targeted case finding and surveillance: Lynch	Work ongoing and approach to roll out in GM in progress
NHS Cancer Screening, targeted case finding and surveillance: Liver	Positive feedback for work in GM on a call with national team July 2022 reflected in Q1 review with national team.
Innovation: Cytosponge	Delivery ongoing
Innovation: CCE	Delivery ongoing
Innovation: FIT	Positive primary care response to use of FIT following PCN sessions and resources from Cancer Alliance. New national guidance produced – action plan developed for GM implementation
Innovation: National and local projects	GM submitted EOIs for the pharmacy and prostate projects – both successful

PCN Engagement

Primary Care Network Cancer Leads x 66

ASKED OF

- To be part of a GM PCN Early Diagnosis of Cancer 'community' to share best practice and lead the implementation of projects to improve the PCN position in relation to early cancer diagnosis
- To shape and lead local training and improvement work with GM Cancer and GP Excellence support
- To be the advocate for cancer early diagnosis in the PCN: sharing information and ensuring uptake of training, education, patient facing communications and referral management processes as advised by the Cancer Alliance
- To connect and network with others beyond their organisations
- To contribute to the design of the GM programme of Early Diagnosis work
- To join calls facilitated by GM Cancer – 6-weekly with additional topic specific as requested by PCNs

OFFER TO

- GM Cancer designed education for GPs and Primary Care professionals – including Webinars – centrally produced in response to local design suggestions, for local engagement and involvement
- GM wide design and delivery of processes and systems to support effective GP referrals – including standardised referral forms, GP system changes at GM level (e.g. algorithms uploaded on GP systems, access to clinical expertise at Pathway Board level
- Patient and public facing communication – GM designed for local delivery
- Access to funding to support PCN level projects which will contribute to improvements in referral pathways

Evaluating the PCN Cancer Lead roles

Purpose of evaluation:

- Assessment of investment and relative benefit
- Shape same or similar roles in future
- Performance framework for future
- Opportunity for feedback from range of partners
- Focus future efforts

Scope of evaluation:

- Review of engagement markers
- Assessment of gains / opportunities progresses
- Performance data reviewed

Greater Manchester Cancer

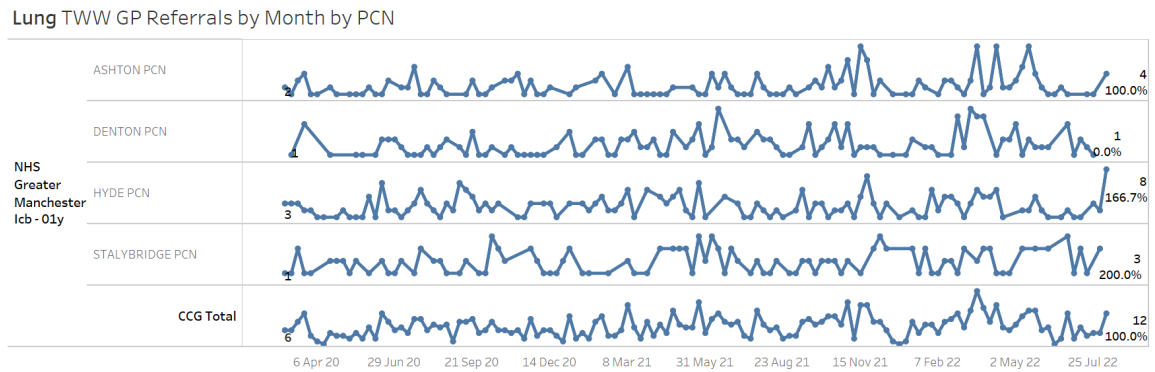
PCN level data

Greater Manchester Cancer: Suspected Cancer Referral (SCR 2WW) Referrals by PCN

Select Referral Type: Lung

Select CCG: NHS Greater Manchester Icb - ..

Select PCN: Multiple values



Greater Manchester Cancer: Conversion Rates by PCN

Select Clock Start Period: All

Select CCG: All

PCNName: All

GP Practice: All

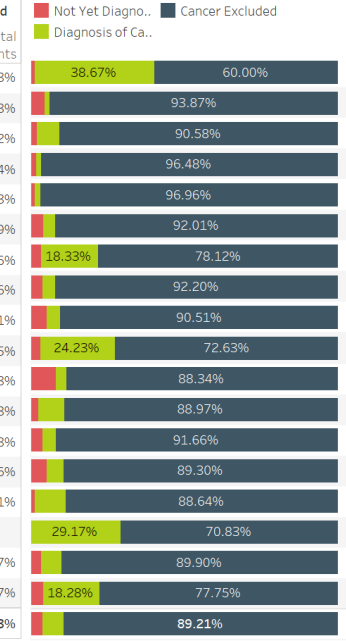
Select Source: All

Counts of cancer diagnoses are only calculated for SCR (2WW) Referrals, Consultant Upgrades, Screening Referrals, and Breast Symptomatic Referrals.

The time period of analysis

Conversion Rates from **All Referral Sources** starting between **Feb 2020** and **Sep 2022**:**All CCGs CCGs, All/Multiple PCNs (see filters), All GP Practices by all Referral/Tumour Types**

Referral Type Desc	Cancer Excluded Patients	Cancer Excluded % of Total Patients	Diagnosis of Cancer Patients	Diagnosis of Cancer % of Total Patients	Not Yet Diagnosed Patients	Not Yet Diagnosed % of Total Patients
Acute leukaemia	45	60.00%	29	38.67%	1	1.33%
Brain or CNS	2,863	93.87%	55	1.80%	132	4.33%
Breast	69,737	90.58%	5,622	7.30%	1,630	2.12%
Breast Symptoms	30,289	96.48%	528	1.68%	577	1.84%
Children's	1,563	96.96%	26	1.61%	23	1.43%
Gynaecological	43,115	92.01%	1,873	4.00%	1,871	3.99%
Haematological ..	4,109	78.12%	964	18.33%	187	3.56%
Head and Neck	42,451	92.20%	1,811	3.93%	1,779	3.86%
Lower Gastroint..	89,192	90.51%	4,218	4.28%	5,139	5.21%
Lung	16,876	72.63%	5,630	24.23%	731	3.15%
Non-specific Sy..	2,704	88.34%	105	3.43%	252	8.23%
Other	2,854	88.97%	276	8.60%	78	2.43%
Sarcomas	3,387	91.66%	174	4.71%	134	3.63%
Skin	51,346	89.30%	3,127	5.44%	3,024	5.26%
Testicular	1,584	88.64%	176	9.85%	27	1.51%
Unknown	34	70.83%	14	29.17%		
Upper Gastroint..	40,711	89.90%	3,049	6.73%	1,524	3.37%
Urological (exclu..	23,909	77.75%	5,621	18.28%	1,220	3.97%
Grand Total	426,769	89.21%	33,298	6.96%	18,329	3.83%



unts and rates should not be used for performance management, as they do not contain any residents diagnosed at providers outside of GM

Greater Manchester Cancer: PTL Metrics - Cancer Incidence

Select Organisation: All

PCNName: All

GP Practice: All

Select Referral Source: All

Tumour Type: All

Emergency Presentation?: All

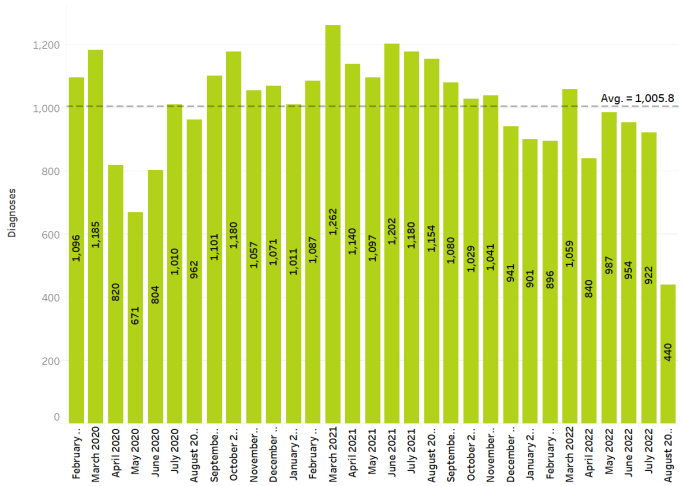
Complete Month?: Yes

Counts of cancer diagnoses are only calculated from SCR (2WW), Breast Symptomatic, and Screening Referrals, and also Consultant Upgrades.

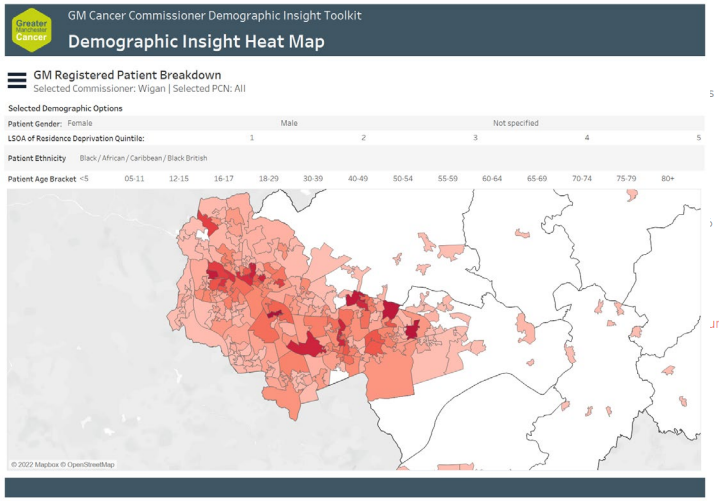
The time period of analysis starts in February 2020 because the cancer registry system at Salford Royal didn't come online properly until the end of January, so GM figures for earlier months would have been artificially reduced.

Incidence of **All Cancers** at **All/Multiple CCGs (see filters), All/Mutliple PCNs (see filters)** :
Between **February 2020** and **September 2022** via **All Referral Sources**

Total Incidence: 31,180



CCG diagnosis counts and percentages should not be used for performance management, as they do not contain any residents diagnosed at providers outside of GM

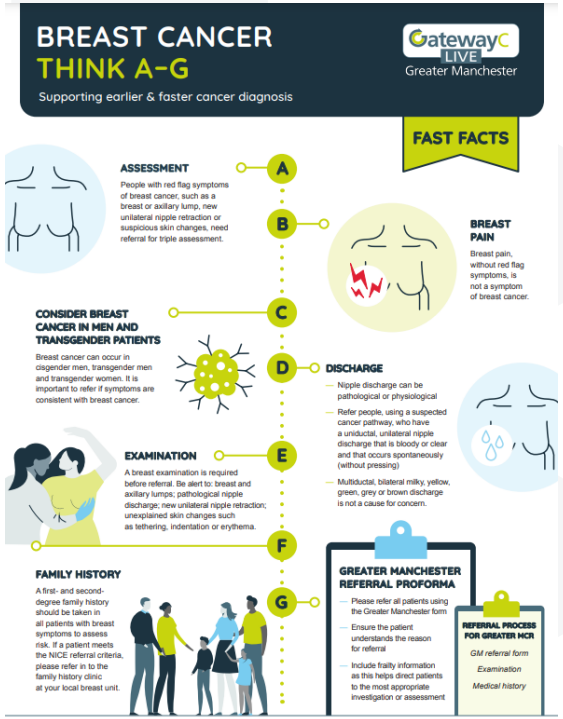


PCN Level GM Cancer PTL Metrics

Data is submitted by each Trust across Greater Manchester and derived from their Cancer Registry Systems.
Data is refreshed daily - Please use the refresh button in the upper left corner in Tableau to update the dashboard.

Greater Manchester Cancer

GatewayC GM Live – ‘Fast Facts’ & A-G Infographics :



https://www.gatewayc.org.uk/free-webinars-gm/

Greater Manchester Cancer

Questions

Personalised Care Programme update

GM Cancer Board
Freya Howle
10.10.22

NHS 2022/23 priorities and operational planning guidance

The NHS Long Term Plan for Cancer states that ***"where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support."***

Cancer Alliances are working with trusts and primary care to offer these personalised care interventions to people with **breast, colorectal and prostate cancer and for other cancers by March 2022 with a further two operational by March 2023**.

We are also required to submit data (via COSD) as part of a quarterly return to monitor delivery of the four main personalised care interventions are available for all cancer patients:

(1) Personalised Care and Support Planning (PCSP) based on Holistic Needs Assessment (HNA)
(2) Health and Wellbeing Information and Support
(3) End of Treatment Summary (EOTS)
(4) Cancer Care Review.

Greater Manchester Cancer

GM Performance - HNAs

Preview of 22/23 Q1 provided by National LWBC team
CAVEAT – data 'lag' for Q4 therefore performance most likely to improve

Number of HNAs offered and/or accepted	2021/22	2022/23	
	Q4	Q1	Change from Q4 to Q1
Date of data extract from COSD	*Aug-22*	*Aug-22*	*Aug 22 extract v Aug 22 extract*
Bolton Hospital	281	364	30%
Christie Hospital NHS Foundation Trust	0	0	-
Manchester University	618	597	-3%
Northern Care Alliance	453	558	23%
Stockport	296	330	11%
Tameside Hospital	6	12	100%
Wrightington Wigan And Leigh	496	586	18%
Alliance total	**2150**	**2447**	**14%**

MANUAL DATA Number of HNAs offered and/or accepted - these figures indicate the level of HNAs that should be captured in COSD in future	2022/23
	Q1
	Manual data - NOT FROM COSD - from Trusts unable to upload to COSD
Bolton Hospital	Not applicable
Christie Hospital NHS Foundation Trust	-
Manchester University	Not applicable
Northern Care Alliance	Not applicable
Stockport	Not applicable
Tameside Hospital	73
Wrightington Wigan And Leigh	Not applicable
Alliance total	73

21/22 Q4 re-run resulted in a 73% increase compared to first run of data
Total HNAs increased from 1239 to 2150

GM Performance - PCSPs

Almost 50% of HNAs completed resulted in a PCSP

Number of PCSPs offered and/or accepted	2021/22	2022/23	
	Q4	Q1	Change from Q4 to Q1
Date of data extract from COSD	*Aug-22*	*Aug-22*	*Aug 22 extract v Aug 22 extract*
Bolton Hospital	83	127	53%
Christie Hospital NHS Foundation Trust	0	0	-
Manchester University	385	342	-11%
Northern Care Alliance	280	328	17%
Stockport	167	185	11%
Tameside Hospital	3	25	733%
Wrightington Wigan And Leigh	140	121	-14%
Alliance total	**1058**	**1128**	**7%**

MANUAL DATA Number of PCSPs offered and/or accepted - these figures indicate the level of PCSPs that should be captured in COSD in future	2022/23
	Q1
	Manual data - NOT FROM COSD - from Trusts unable to upload to COSD
Bolton Hospital	Not applicable
Christie Hospital NHS Foundation Trust	-
Manchester University	Not applicable
Northern Care Alliance	Not applicable
Stockport	Not applicable
Tameside Hospital	Not applicable
Wrightington Wigan And Leigh	Not applicable
Alliance total	-

21/22 Q4 re-run resulted in a 76% increase compared to first run of data
Total HNAs increased from 598 to 1058

Key Updates/Successes – National Standards

Personalised Care

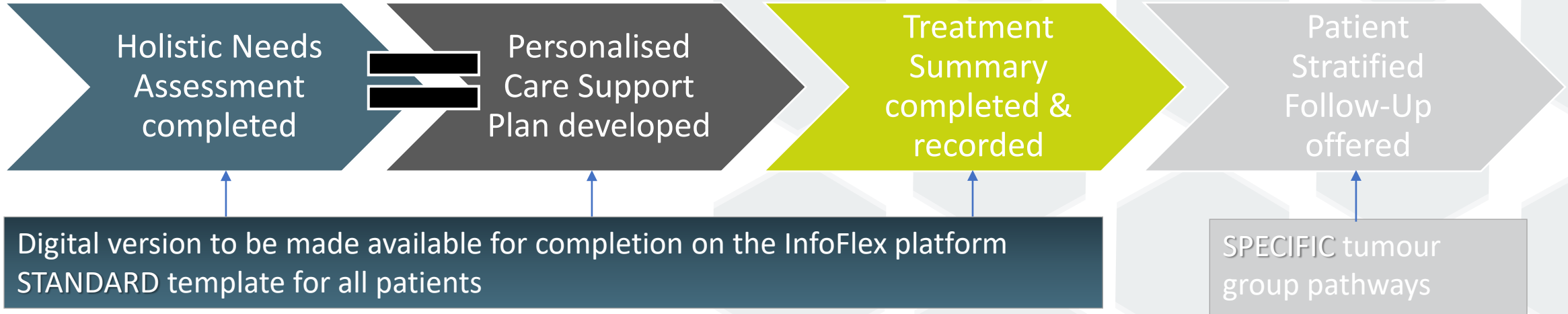
Delivery plan priority	Update

Complete 21/22 PSFU objectives by Q1:
• Ensure **fully operational & sustainable PSFU pathways for breast, prostate, colorectal and one other cancer (gynae)**
• all appropriate patients are placed on these pathways with **digital remote monitoring.**
This should include working to ensure digital remote monitoring system (DRMS) delivery is on local digital roadmaps.
	• PSFU pathways designed across multiple tumour groups and many currently being offered to patients without the standardised support of a DRMS.
	• InfoFlex (GMs DRMS) rollout progressing well – set up clearer reporting governance between digital partners, Trust network leads and GM Cancer.
	• Working with clinical teams through GM Cancer PWBs to design & develop tumour group pathways that will be built for use across all Trusts in GM.
	• Key pathway updates:
	  • *Breast – live at Tameside*
	  • *Colorectal – final approval of DRMS design at PWB in Sept 22*
	  • *Prostate – awaiting approval of patient portal*

Roll out PSFU for two further cancers. At least one of these pathways should be endometrial cancer. One of these should be operational by September 2022; and both by March 2023 with DRMS.	• Project plan in place for 14 pathways in total – weekly progress meetings with infolfex • Clear process of development, testing and approval in place involving clinicians, patients and PWBs. • Upper GI & Renal pathways most developed and will be remain a focus
Ensure the four main personalised care interventions are available for all cancer patients: (1) Personalised Care and Support Planning (PCSP) based on Holistic Needs Assessment (HNA) (2) Health and Wellbeing Information and Support (3) End of Treatment Summary (EOTS) (4) Cancer Care Review	• Positive progress – check-in with National LWBC team in Sept 22 to review quarterly return – HNA & PCSP has improved from Q4 21/22 to Q1 22/22 for GM. • Working groups to be established for (1)-(3) to lead on implementation of GM standards • (4) CCR standards for primary care & a new cancer diagnosis template for GP practices to use has been co-designed and in second circulation for feedback following initial updates.
Engage with trusts to improve data quality across personalised care interventions in COSD returns.	• Requested baseline data for how the interventions are being delivered and recorded currently (pre InfoFlex rollout) from each Trust by Tumour Group from the Personalised Care Leads.

Greater Manchester Cancer

Interventions – how are they delivered?



Majority of Trusts deliver these interventions but it a number of different ways which are recorded differently. They could be:

- *A conversation*
- *A telephone call*
- *Part of a clinic appointment*

However the intervention is delivered we need the ability to RECORD in a standardised way.

SPECIFIC tumour group pathways

Developed by lead Trust & clinical reps

Approved by PWB – clinicians & patients

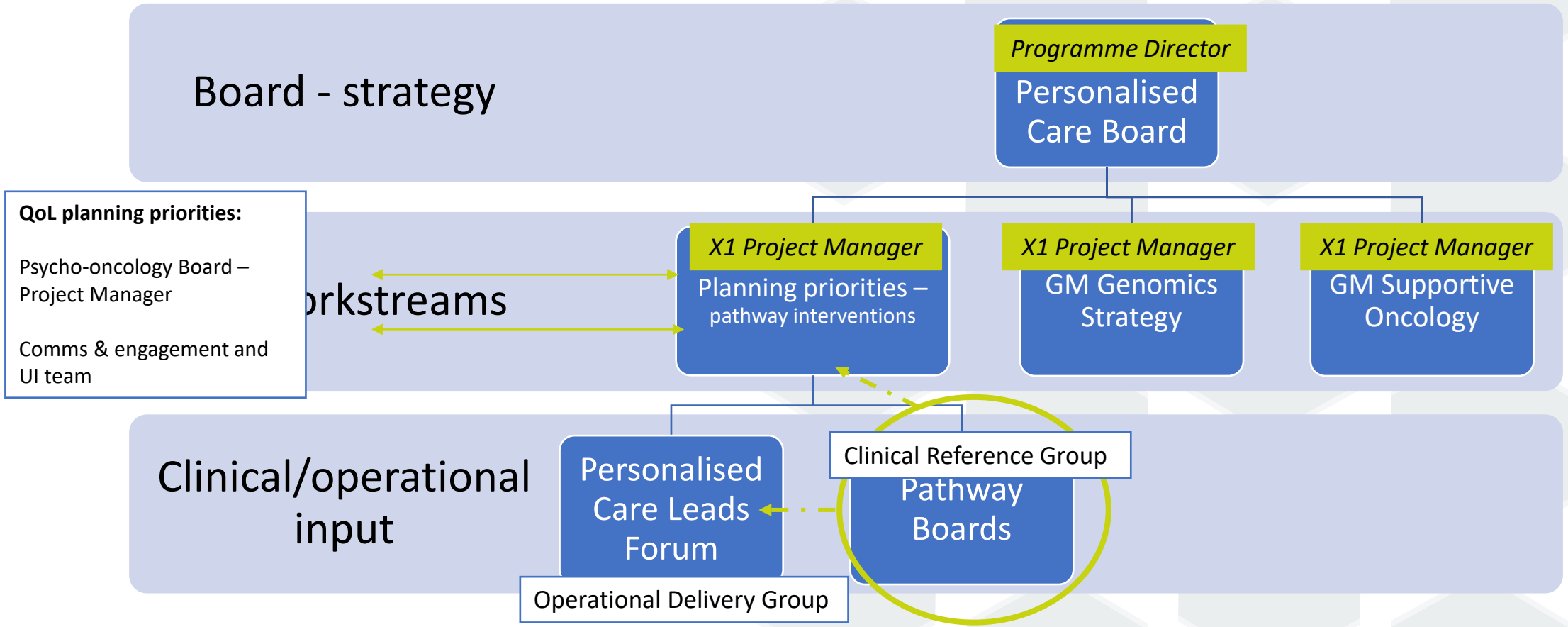
Greater Manchester Cancer

Key Updates/Successes – National Standards

Quality of Life	Delivery plan priority	Update
	Deliver **communication & engagement activities to achieve a response rate >50% and increase uptake within underrepresented groups**, with a focus on ethnicity, age and deprivation.	• The user involvement programme will work with UI representatives to support the promotion of the survey through their networks. • Comms and engagement team will support the promotion of the QoL to increase uptake and work with the patient engagement lead to target underrepresented patient groups.
	Complete a **mapping and development plan** for two Quality of Life priority areas: (1) psychosocial support (2) a Quality of Life priority area identified for local intervention from the recently launched CancerData Dashboard.	• Clinical lead identified and gap analysis (completed 2017) has been shared with the National Team. • Alliance representatives attending and presenting at the 'Improving mental health for people affected by cancer conference' in December. • GM Cancer Academy developing a psych level 2 hybrid training package.

Personalised Care Programme:
GM Workshop outcomes – what do people want?

Personalised Care Programme – governance



Communications and Engagement

Anna Perkins
October 2022

Key Updates/Successes (1) – as per planning priorities

Delivery plan priority	Update
Getting people into the system: Timely presentation	• Continued sharing of national and local campaigns via own channels and paid for socials and media. Investment in channels to drive traffic and engage target audiences. Continued development and sharing of monthly campaigns calendar with partner orgs and VCSE (circa 120 orgs total) • Production of specific tools to support **challenged pathways** (breast symptoms animation video produced in line with video suite) • Development of additional language formats of 2ww letters (planned development into video via AskDoc – multiple languages, also supports low literacy rates). Ukrainian translations in development for existing multi-language materials • Projects: Supporting SRCXR, Black Men's Health Prostate project, NHS-Galleri Trial with robust communications plans and activation (where appropriate) including online advertising, social media, partner engagement, organic and paid media and outdoor advertising. • Second series of podcast launched: first episode focussing on lung projects. Early Diagnosis episode is next to be recorded, planned broadcast September. • Cancer Alliance Communications team has expanded with 2 new members to increase capacity to deliver objectives set out in the Planning Guidance and via the Early Diagnosis programme
NHS Cancer Screening, targeted case finding and surveillance: NHS Cancer Screening	Supporting the screening programme in the development of a new communications strategy for the three national cancer screening programmes in GM – in development

Key Updates/Successes

- Website continues to perform well since launch in March. Editor training ongoing with GMC team members.
  - Best performing pages: Conference, Awards, Team and SRCXR

- Social media – engagement with channels continues to grow.
  - Twitter – 4,183 (+143 since May 22)
  - Facebook –365 (+25 since May 22)
  - LinkedIn – 397 (+49 since May 22)
  - Instagram – 115 (+22 since May 22)
  - YouTube – 108 (+ 15 since May 22)

Paid, targeted, social media advertising is also supporting SRCXR project at present. This has led to a significant rise in impressions (stats right indicate previous 7 days activity)

	Page title and screen class	↓ Views	Users	New users
	Totals	18,801 100% of total	7,595 100% of total	7,386 100% of total
1	Greater Manchester Cancer – Greater Manchester Cancer is the cancer programme of Greater Manchester's devolved health and social care system.	3,459	2,440	2,120
2	Greater Manchester Cancer Conference 2022 – Greater Manchester Cancer	1,426	952	740
3	Greater Manchester Cancer Awards 2022 – Greater Manchester Cancer	916	658	555
4	Our team – Greater Manchester Cancer	827	468	183
5	"Drop-in" chest x-rays launch in Heywood, Middleton and Rochdale – Greater Manchester Cancer	728	587	579
6	Prehab4Cancer – Greater Manchester Cancer	593	295	237
7	Lung – Greater Manchester Cancer	529	217	98
8	Chest x-ray – Greater Manchester Cancer	441	344	331
9	About us – Greater Manchester Cancer	392	242	33
10	Genetic Testing – Greater Manchester Cancer	382	170	102

Impressions: Facebook: 25,171 (+1,475.2%)
Instagram: 3,035 (+1,149%)
Twitter: 7,511 (+50.1%)
LinkedIn: 790 (+8.2%)

Key Updates/Successes

- Press:
  - SRCXR M.E.N article performed very well
  - Rochdale Observer and Middleton Guardian – supporting SRCXR
  - BBC Radio Manchester – Sun Safety radio interview


'Drop-in' chest x-ray service launches for Manchester residents in a bid to catch cancer early

From Monday July 11, members of the public from Bury, Heywood, Rochdale and Middleton are able to attend their lo hospital for a chest x-ray, without needing to see a GP or book an appointment in advance

SHARE

By Fiona Callow
09:20, 11 JUL 2022

MOST READ

Residents from Bury, Heywood, Rochdale and Middleton will be able to attend their local hospital for a chest x-

Paid-for features in the Manchester Evening News (online)				
Date	Title	Topic	Article page views	Article users
4th February 2022	Ballet-dancing lung cancer survivor urges those with worrying symptoms to seek help this World Cancer Day	Lung cancer - WCD 22	3,400	3,000
31st March 2022	Ultramarathon runner with a 'muscle strain' turned prostate cancer urges others to check their risk	Prostate cancer	2,400	1,900
17th May 2022	"It's free, it's a simple test and it could literally save your life"	Bowel cancer screening kit	4,500	3,400
11th July 2022	**Drop-in' chest x-ray service launches for Manchester residents in a bid to catch cancer early**	**Lung - chest x-ray (Bury and Rochdale)**	**5,300**	**4,300**

Key Updates/Successes

- **Media training** of clinical representatives on-going to support with future proactive and reactive media opportunities.

- **Conference and awards** – planning well underway on both events. Entries to date represent a good range of projects from across Greater Manchester. Conference and awards represent significant opportunity for system-wide engagement.

- **Annual report launched July 22**

Patient and Public Involvement & Experience

Anna Perkins
October 22

Key Updates/Successes – as per planning priorities

Delivery plan priority	Update
Patient and public involvement and engagement is an enabling function across all planning priorities.	The team has conducted a review of the current UI programme with both UI members and the workforce, to understand how the programme can be improved to ensure the voice of patients is heard and considered across our work programmes. A Band 7 PPIE manager role is also in development to support this work.
Quality of Life QoL Survey CPES and U16 CPES Surveys	 UI Programme will work with representatives to support the promotion of the survey through their networks As above

Key Updates/Successes

- **Progress of User Involvement Review *Your Voice: Shaping the way we work***

  Mustard has now completed its 1:1 interviews, focus groups, online community and survey and the results are being analysed. A full report will be available to share with the Alliance and the public in October. We anticipate the development of a work programme to address any actions identified as part of this exercise to make improvements to the programme.

- **Coffee and cake catch up UI event**

  Engagement events for UI members developed based on feedback: In-person event were scheduled for Friday 16th September and virtual event Monday 19th September by unfortunately were postponed due to the period of mourning and are in the process of being re-scheduled. The agenda has been co-designed. Other engagement events are now being scoped and considered.

- **Education packages for new members and the workforce – in development**

Project scoping being undertaken with plans to have education package finalised by the end of the financial year, with two separate training modules for both service users and staff. Feedback from the Your Voice review will also feed this and the modules will be co-produced.

Cancer Board 10 October 2022

Title of paper:	Lung Cancer – One Stop Clinic. Interim Impact Statement
Purpose of the paper:	To provide the GM Cancer Board with an initial assessment of the Lung One Stop Clinic model, following its launch 17.06.22. This paper assesses the impact to cancer pathway metrics, quality of care, patient experience, operational performance through qualitative and quantitative measurement. This paper additionally outlines the proposed next steps for the One Stop Clinic, the next stages of evaluation and how this model may be adopted.
Summary outline of main points / highlights / issues	• Introduction and the rationale for the One Stop Clinic • The delivery model • The aims, objectives and Key Performance Indicators (KPIs) • Impact on cancer pathway metrics, quality of care, patient experience and operational performance • Proposed next steps
Consulted	Lung One Stop Clinic Project Group
Author of paper and contact details	**Name:** Dr Matthew Evison **Title:** Lung Cancer Pathway Director, GM Cancer **Email:** m.evison@nhs.net **Name:** Lisa Galligan-Dawson **Title:** Performance Director, GM Cancer **Email:** lisa.galligan-dawson@nhs.net

Contents

1. Executive Summary

This paper provides an interim assessment of the Lung One Stop Clinic, launched 17.06.22.

This service is aims to reduce the time from treatment referral to DTT (Decision to Treat) for a highly complex cohort of patients suitable for curative treatment, where the best treatment modality is not clear. The uncertainty is often driven by a higher level of risk from treatment-related complications due to co-morbidity, frailty and other health concerns. Treatment decision-making, in this scenario, most commonly sits between surgical resection and curative-intent radiotherapy in early-stage disease.

Since the launch and until 01.09.22, 59 patients have attended the One Stop Clinic. There have been 0 DNAs and 0 Cancellations. The clinic has been fully staffed across its range of specialties at every clinic. 35 (59%) of the 59 patients are from the most deprived areas of GM (IMD 1 & 2).

The key performance in this interim assessment is:

Protocol	Current Performance
Screening and treating tobacco dependency	100%
Screening and treating malnutrition	100%
Screening and treating frailty (Oncogeriatrics)	89%
Screening and treating alcohol dependency	100%
Screening and access to Prehab4Cancer	100%
Proportion of patients with DDT on day of clinic	86%

Time from referral acceptance to DTT ≤7 days	54% (98% in 14 days)
Proportion of patients with NSCLC treated with curative intent treatment	100%
Median Length of Stay (Surgery)	6.5 days
Median CTCCU Stay (Surgery)	1 day

The median wait from Referral Acceptance to DTT is 7 days compared to 35 days in the pre-clinic launch cohort. **A median saving of 28 days.**

The median wait from Referral Acceptance to FDT is 25 days, compared to 40 days in the pre-clinic cohort. **A median saving of 15 days.**

100% of patients (59/59) said they felt 'very well supported' when asked 'Overall, how well supported did you feel by the medical teams involved in your care to make this decision about your treatment'

All 59 patients answered the following question 'Overall, please rate your experience of care 1-10 (1 being the worst experience of care and 10 being the best experience of care)'. **The overall rating was 9.5/10.**

2. Introduction and the rationale for the One Stop Clinic

Introduction

Lung cancer is the single biggest cause of cancer-related death in the UK (35,000 deaths per year), and disproportionately affects the most deprived communities. GM is the third most deprived ICS in England, and diagnoses approximately 2500 lung cancers per year. According to the National Lung Cancer Audit (2022) the median overall survival in patients diagnosed with lung cancer across Greater Manchester in 2019 was 330 days, and across the 10 CCGs 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. This is in comparison to the England median overall survival of 316 days.

Delays in diagnosing and treating Lung Cancer leads to stage shift and a reduction in life expectancy. In 2017, the IASLC Lung Cancer Staging Project for the 8th Edition of the staging manual confirmed the importance of tumour size in driving lung cancer survival, demonstrating an 8-10% decrease in survival for every 10mm increase in size. It highlights in lung cancer that millimetres do matter (Booton, 2020). Much work is underway focussing on early diagnosis – including campaigns promoting the symptoms of lung cancer, education, targeted lung health checks and a self-referral chest X-ray project.

Equal focus is required to improve the management of pathways for patients entering secondary care with suspected cancer and those diagnosed with lung cancer. A deep-dive study into the lung cancer pathway for patients undergoing surgery in Greater Manchester during the covid pandemic in 2020 (Booton, 2020) emphasises the importance of accelerated diagnostic and treatment pathways. Stage comparison was assessed using baseline imaging from the referring hospital, alongside the CT performed on the day of surgery (undertaken due to the covid-19 pandemic) in 62 patients. 29 patients (46%) had stage shift identified, confirmed pathologically, in the time between initial diagnosis and treatment. The proportion of patients suffering a stage shift increased with longer pathways, being most pronounced in those with a pathway beyond 62 days. This audit brings into focus what we already know about disease progression and underlines the need for timely access to diagnosis and treatment. The impact on the patients waiting the longest is also evidenced through the 104-day harm review process, where 47% of the harm recorded in GM (20/21) relates to lung cancer.

The Rationale for Change

In Greater Manchester (GM) Lung Cancer sectorised MDTs are in place to agree treatment decisions. For some patients this decision making can be straight forward, but there is a highly complex cohort suitable for curative treatment, where the best treatment modality is not clear. The uncertainty is often driven by a higher level of risk from treatment-related complications due to co-morbidity, frailty and other health concerns. Treatment decision-making, in this scenario, most commonly sits between surgical resection and curative-intent radiotherapy in early-stage disease. This is a time sensitive disease, and for this cohort, the pathway has historically required patients to attend separate (and sometimes multiple) appointments with surgeons, anaesthetists and oncologists across a number of hospitals, and in many cases have their case discussed in a separate high-risk surgical MDT to reach a treatment

decision. The most recent patient data prior to the clinic launch showed a median wait time from referral to DTT for this patient cohort (data provided by local cancer services) of **35 days (IQR 12-65, range 0-179)**. This is just the time to make a decision to treat, there is then the wait for treatment to start. This adds significant risk to disease progression and stage change, and from curative treatment to palliative intent as well as poor patient experience. The rationale for the One Stop Lung Clinic is to address the pathway for this highly complex patient cohort, getting to a treatment decision earlier. It also helps address two of the key domains within the Lung Getting it Right First Time (GIRFT) report; delivering effective treatment and effective multidisciplinary working.

3. The Delivery Model

The Lung One Stop Clinic launched on 17 June 2022, initially with one clinic per week. The second weekly clinic is expected to go live in March 2023. The design and format of the clinic day has been fully co-produced with user involvement:

- A clinical service for patients across Greater Manchester
- A multi-disciplinary approach to support shared decision making when a patient has different curative intent treatment options between surgery and radiotherapy
- The opportunity to meet with different treatment specialists in a single morning (surgeons, thoracic anaesthetists and clinical oncologists) supported by recommendations from a multi-disciplinary team meeting on the day, with the same clinicians the patients will meet
- Robust support team for each patient (including one specialist nurse for each patient that stays with the same patient through each consultation to support understanding & discussion)
- Implementing robust assessment protocols that include filmed functional testing (sit to stand testing) to be viewed during the MDT discussion, cardiac risk

profiling with finger-prick pro-BNP testing, and the systematic implementation of patient priority questionnaires

- A protocolised & standardised assessment to identify interventions to optimise all aspects of a patient's health and minimise the risk of treatment related complications:
    - Nutritional assessment & intervention
    - Tobacco dependency treatment and support provided on the day
    - Prehab4cancer exercise specialist review on the day – support referral and uptake to the programme
    - Alcohol assessment & intervention
    - Oncogeriatrics specialist review for frailty & co-morbidity management
    - Lung cancer physician review for respiratory co-morbidity management and extra support in decision-making when needed
    - Signposting to local holistic care services through St Ann's Hospice team
- Provide a holistic service with a kind & caring approach that facilitates the provision of detailed information in an understandable way and in a supportive environment that facilitates shared decision making (on the day of clinic where possible)
- **Accelerate pathways to lung cancer treatment**

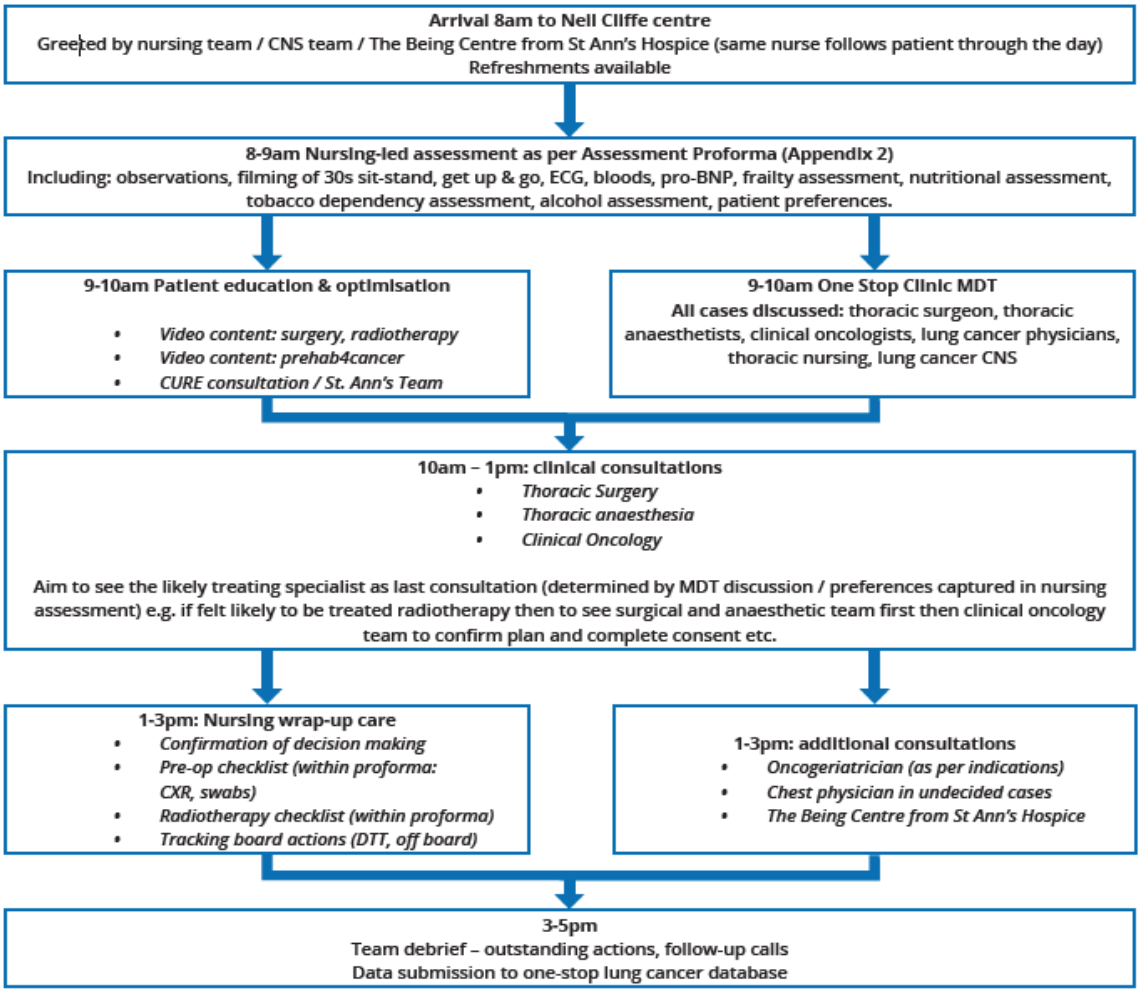
The service is run from the Neil Cliffe Centre in Wythenshawe Hospital. A relaxed and comfortable environment has been created for up to 6 patients per clinic, and their relatives.

As well as the core clinical services – thoracic surgery, thoracic anaesthesia, chest physicians, thoracic oncology, and specialist nurse input the clinic is supported by oncogeriatricians, CURE smoking cessation service, Prehab4cancer (diet, exercise, psychology), and St Ann's Hospice. Where transport is needed for patients, this is

arranged directly via the MFT thoracic service (taxi's ordered and paid by the clinical service) and patient refreshments are provided throughout the day (and free of charge parking for those driving to the appointment).

This is much more than a traditional 'joint clinic', which brings together surgical and oncology consultations; the clinic offers a complete wrap around for the patients to aid the shared decision making and optimisation in preparation for whatever treatment is chosen. Patients are counselled over their tobacco dependency and alcohol intake. The CURE programme (initially designed for inpatient use) allows patients to leave with treatment – vaping devices and e-liquids, nicotine replacement patches and follow up appointments. The prehab4cancer team enrol patients into their programme, and patients are able to leave the clinic with a prehab exercise plan and booked assessments with exercise specialists in their local facilities as well as access to dietician and psychological support.

These are crucial interventions to optimise the patients. Smoking cessation reduces the risk of peri-operative complications, increases the efficacy of radiotherapy, reduces the risk of disease recurrence and improves overall survival. Prehabilitation has been shown to reduce peri-operative complications by 50% and reduce length of stay by 2 days. The GM Prehab4cancer programme has also been shown to lead to long term behaviour change with increased activity levels 12 months after participating in the programme. The way in which the clinic operates is as follows:



Patients whose outcome is for surgery leave with their pre-operative and anaesthetic assessment completed, and a date for surgery agreed. Patients that will undergo radiotherapy are consented for treatment on the day of clinic and therefore can move directly to a planning scan at The Christie.

Patient Information

A wide range of patient information about how the clinic operates is sent to the patients in advance of attendance. Screens in the main waiting area play a range of educational information, and snippets from each of the services to give patients and their relatives

overviews of the surgical and radiotherapy pathways and what to expect. Patients are also provided with links to all of the videos.

4. The aims, objectives and Key Performance Indicators (KPIs)

Ultimately, this new clinic model aims to eliminate multiple appointments across a range of providers and ensure this complex patient cohort have a treatment decision sooner, leading to better patient outcomes and experience. Therefore, the primary metrics for this service are:

- **Proportion of patients in which a decision to treat is made on the day**
- **Median time from referral acceptance to decision to treat**

A range of supporting KPI's have been established, which will be monitored on a quarterly basis, and will form part of the overall evaluation of the service. In addition to these delivery metrics, it is expected that there will be an improvement in the median wait times to from treatment referral to date of first treatment and ultimately (with delivery of other initiatives) an improvement to overall cancer pathway performance.

Greater Manchester Cancer

NHS
Greater Manchester
Integrated Care

KEY PERFORMANCE INDICATORS

Adherence to optimisation protocols – reported quarterly

Protocol	Red rated	Amber rated	Green rated
Tobacco	<75%	75-90%	>90%
Nutrition	<75%	75-90%	>90%
Oncogeriatrics	<75%	75-90%	>90%
Alcohol	<75%	75-90%	>90%
Prehab4Cancer	<75%	75-90%	>90%

Pathway Performance – reported quarterly

Protocol	Red rated	Amber rated	Green rated
Proportion of patients with a decision to treat made on the day of clinic	<50%	50-75%	>75%
Time from referral acceptance to decision to treat ≤7days	<50%	50-75%	>75%

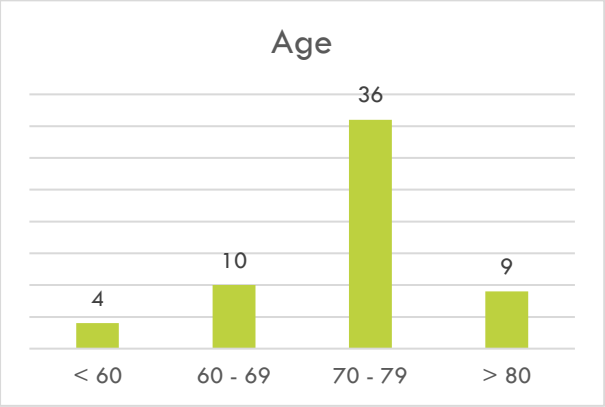
Adherence to optimisation protocols – reported quarterly

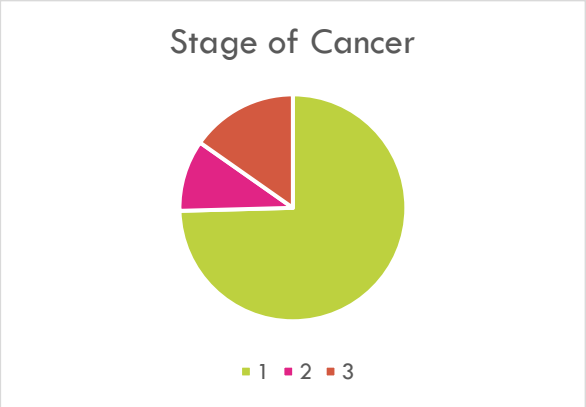
Protocol	Red rated	Amber rated	Green rated
Proportion of patients treated with curative intent treatment	<75%	75-90%	>90%
Median Length of Stay (Surgery) Median CTCCU stay (Surgery)	>14 days >5 days	7-14 days 3-5 days	<7 days <3 days
30-day mortality	>5%	3-5%	<3%
90-day mortality	>10%	5-10%	<5%

5. Initial impact of the One Stop Service: Quality of care, operational performance and experience of care

This initial evaluation includes all patients seen in the clinic up until 01 September 2022. 59 in total in 12 fully staffed clinics. There have been no cancellations or DNAs.

The age range and stage distribution of the 59 patients is as follows:





Tables 1-3 outlines the current performance of the One Stop Lung Cancer Clinic

Table 1: Adherence to Optimisation Protocols

Protocol	Current Performance
Screening & treatment for tobacco dependency	100%
Screening & treatment for malnutrition	100%
Screening & treatment for frailty (Oncogeriatrics)	89%
Screening & treatment for alcohol dependency	100%
Screening & access to Prehab4Cancer	100%

Tobacco dependency

- 59/59 (100%) screened for smoking status

- 18/59 (31%) current smokers
- **18/18 (100%) approached by the CURE team & offered treatment & support**
- 17/18 (94%) agreed to CURE treatment, 1 patient declined referral (94% uptake)

Nutrition

- 59/59 (100%) screened for risk of malnutrition
- 11/58 (19%) patients at moderate-high risk of malnutrition
- **59/59 (100%) completed nutritional protocol interventions correctly**

Oncogeriatrics

- 59/59 (100%) screened for frailty (CFS & AMT)
- 9/59 (15%) patients with CFS ≥5 +/- AMT <7/10
- **8/9 (89%) seen by oncogeriatrics protocol adherence 89% (target >90%) – 1x patient declined to see**
- A total 21/59 (36%) seen by oncogeriatrics due to additional medical problems & co-morbidity management

Alcohol dependency

- 59/59 (100%) screened for alcohol intake
- 9/59 (15%) identified at high risk from alcohol intake
- **59/59 (100%) completed alcohol protocol interventions correctly**

Prehab4cancer

- 59/59 (100%) screened for referral and engagement with P4C
- 2 patients had contra-indications to community P4C and 1 patient declined P4C
- 34/59 (58%) additional recruitments to the programme (not previously referred or engaging prior to the one-stop clinic)
- Overall, 56/59 (95%) patients engaging with the P4C programme
- **Protocol adherence 100% (target >90%)**

Table 2: Pathway Performance

KPI	Current performance
Proportion of patients with DDT on day of clinic	86%
Time from referral acceptance to DTT ≤7 days	54%

DTT on day of clinic

- 51/59 (86%) had a decision to treat on the day.
- Of the remaining 8 patients:
    - 4/8 completed a DTT day 3 after the clinic
    - 3/8 completed a DTT day 4 after the clinic
    - 1/8 completed a DTT day 7 after the clinic (patient required a skin biopsy to exclude metastases - new skin lumps identified at clinic).
- **Performance 86% (target >75%)**

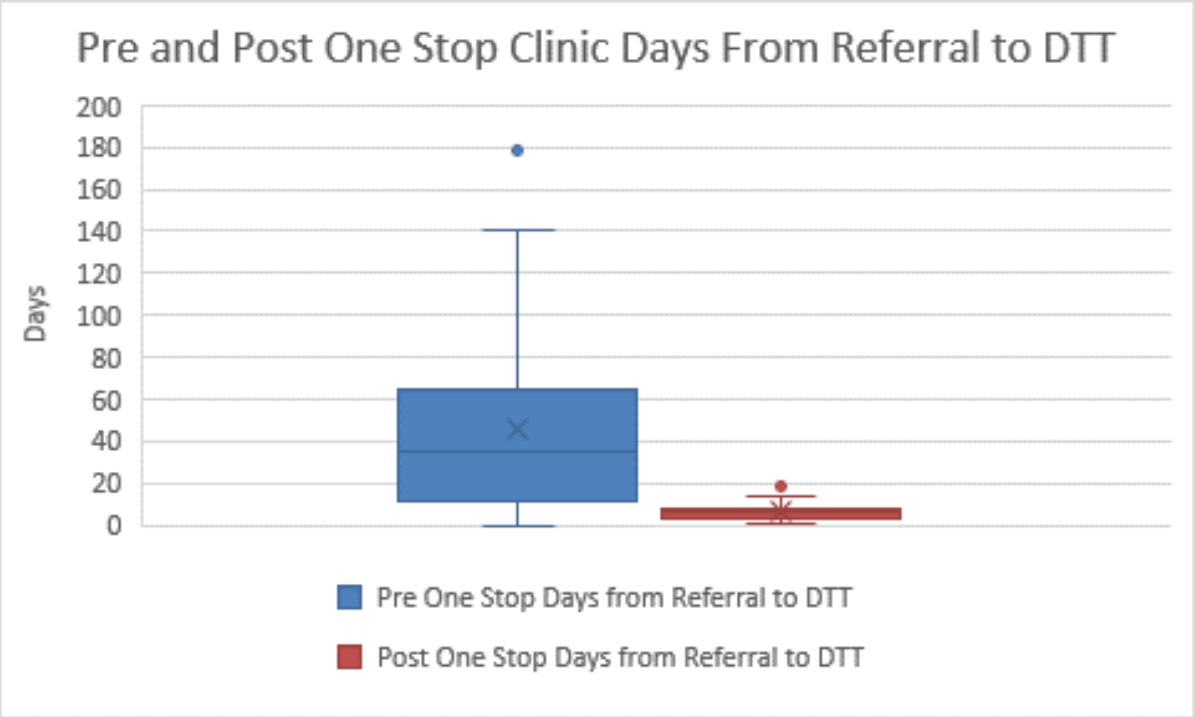
Referral Acceptance to DTT

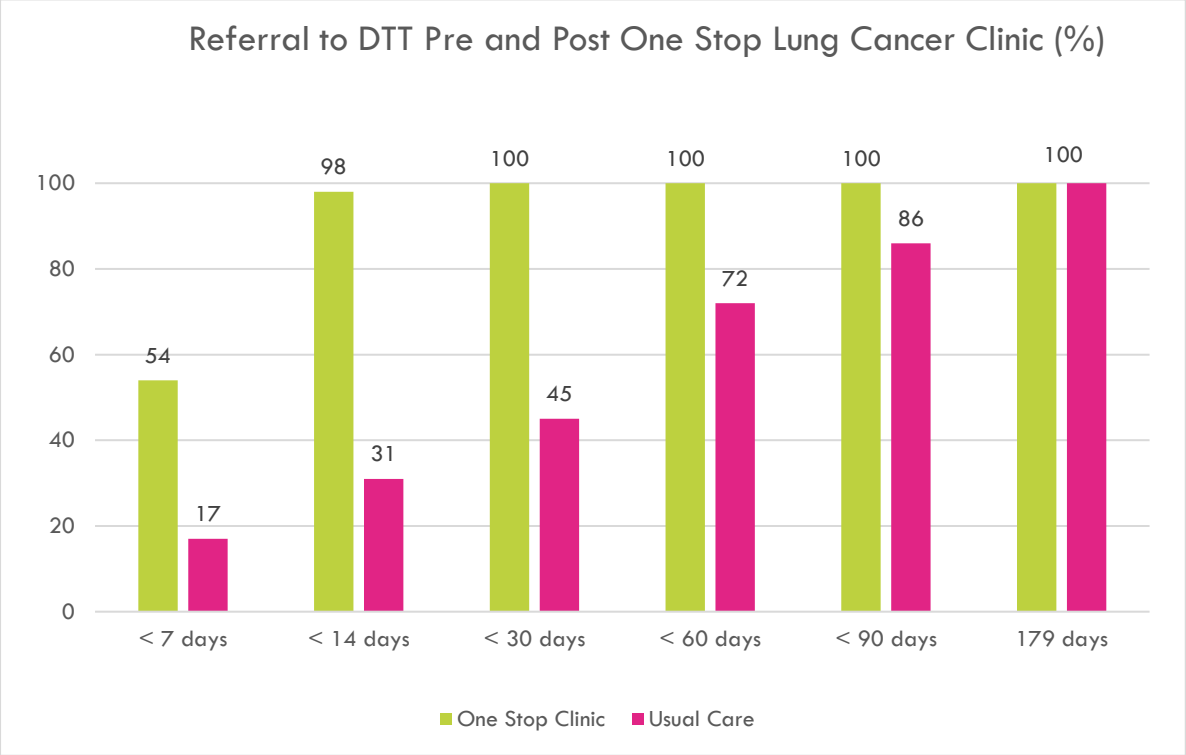
- 32/59 (54%) had a DTT within 7 days of the referral being accepted.
- 58/59 (98%) had a DTT within 14-day of the referral being accepted.
- **Median time from referral to DTT is 7 days (IQR 3-8, range 1-18)**
- Prior to implementation of the one-stop clinic the median time from referral to DTT was 35 days (IQR 12-65, range 0-179).
- **Protocol adherence 54% (target >75%)**

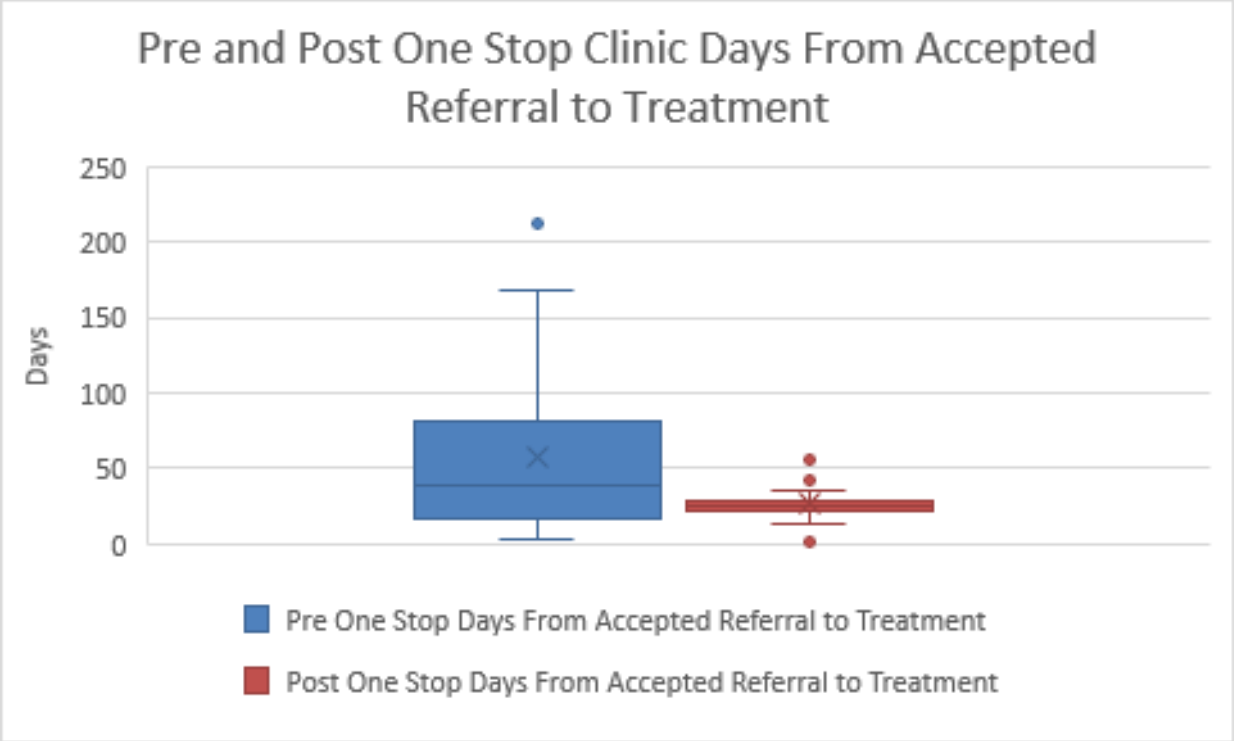
Of note, all but one patient (which was patient choice) would have been seen within 7 days had the second clinic been open. 18 of the 7 day breaches were patients accepted on a Thursday, who were unable to be invited to the clinic the following day on the Friday.

Referral acceptance to date of first treatment

The improvement in time taken to reach a DTT has also translated into improvements in the overall time to first definitive treatment with an improvement in median time from referral acceptance to date of treatment from 40 days to 25 days, comparing the patients who attended the clinic and have completed treatment, and the pre-clinic cohort (identified from MDT as being suitable for the clinic before the launch).




Referral to DTT Pre and Post One Stop Lung Cancer Clinic (%)
100
80
60
40
20
0
54
17
98
31
100
45
100
72
100
86
100
100
< 7 days
< 14 days
< 30 days
< 60 days
< 90 days
179 days
One Stop Clinic
Usual Care



Treatment Outcomes

100% (57/57) of patients with NSCLC patients went on to complete curative intent

There were 2x cases of typical carcinoid tumours that did not require intervention.

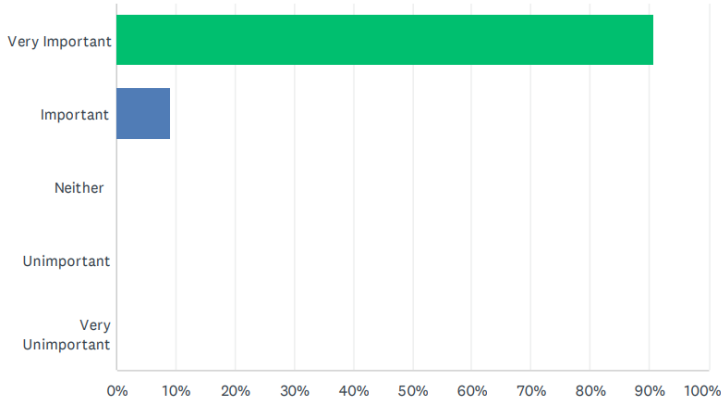
Proportion of patients with NSCLC treated with curative intent treatment	100%
Median Length of Stay (Surgery)	6.5 days
Median CTCCU Stay (Surgery)	1 day

- **Performance median LoS <7 days & <3 days**

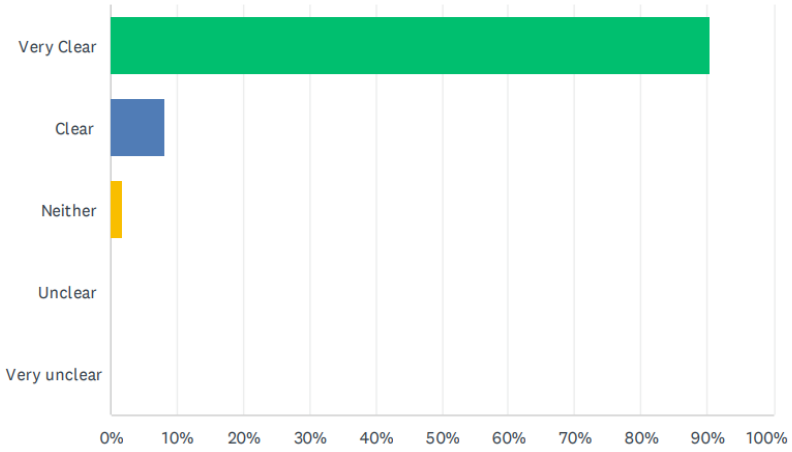
Patient Survey & Experience of Care

All patients attending the one-stop clinic have been asked to complete an experience of care survey and 100% of patients have completed this survey.

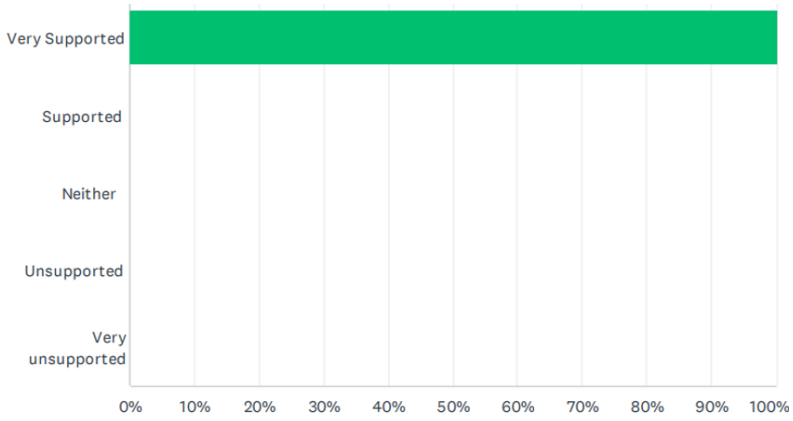
1. **How important is it to you to meet all the different teams that give treatment for lung cancer before making a decision about your best treatment option?**



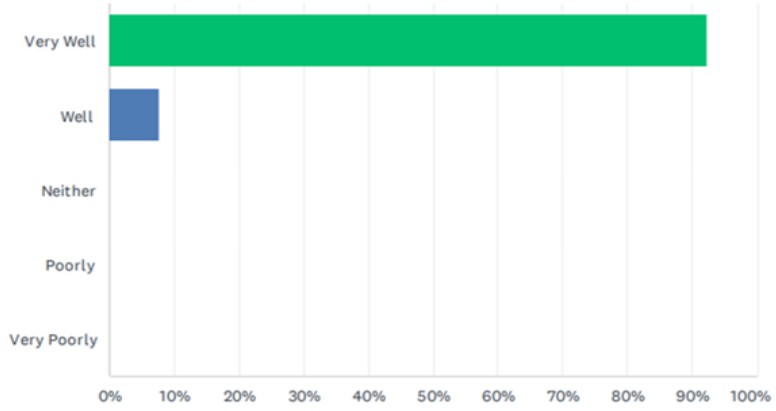
2. **Overall, how clear and understandable was the information given to you by all of the different teams to help you make a decision about which treatment is best for you?**



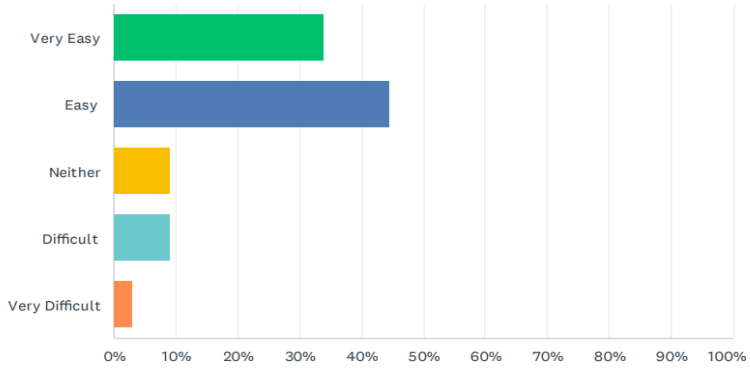
3. **Overall, how well supported did you feel by the medical teams involved in your care to make this decision about your treatment?**



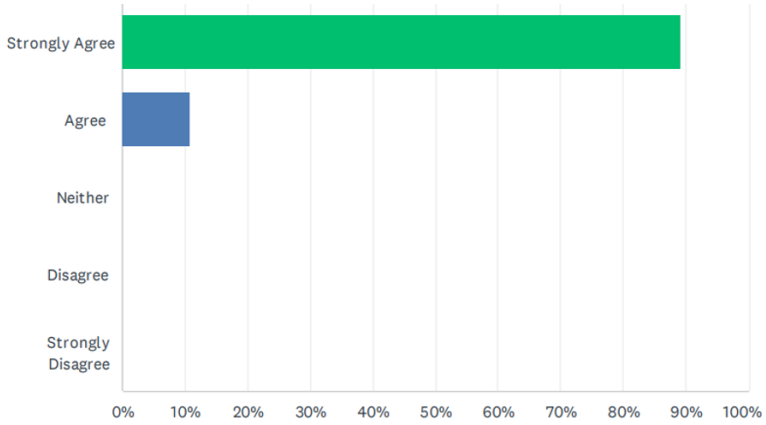
4. **Overall, how well did your medical teams listen to your concerns & questions and ensure these were answered satisfactorily?**



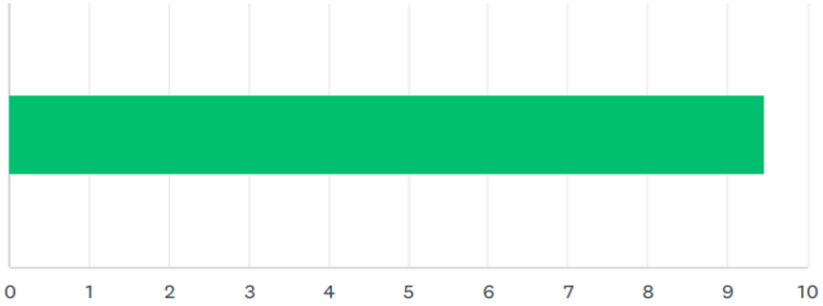
5. **How difficult was it for you to make the decision about which treatment would be best for you?**



6. **How do you feel about the following statement – 'seeing all the different teams in the same clinic on the same day is the best way to discover all the information required to make an informed decision'**



7. **Overall, please rate your experience of care 1-10 (1 being the worst experience of care and 10 being the best experience of care)**



Patients were also asked to provide free text comments on their experience. A representative selection is included overleaf.

From arrival at the unit everyone was friendly and helpful.
Everything was explained fully going home more of a positive outlook - many thanks to all concerned
You provide an exceptional service cannot thank everyone enough
Very good clinic that should continue at one hospital which helped retain information better
Clear to tell family outcome after 1 day of appointments
Excellent staff involvement. Thank you
All staff clear all staff supportive and personal
My experience has been excellent. No issues at all. Treated excellently by all staff here.
Delighted by our experience. Happy about our treatment.
All good. Every member I met and spoke with put me at ease, explained all processes clearly.
The decision to see different doctors in order to make a decision is very good. Thank you all !!!
Lovely atmosphere, well looked after and extremely informative. Very pleasant experience
The One Stop Clinic was the best way to find my cancer result and treatment for it. Everybody was kind & helpful
Seeing the surgeon, oncologist & anaesthetist, has helped me with my decision
I can now go home & discuss it with my family
From the very beginning I have had excellent support from everyone
Information and discussions have been open and frank which I think is important and helpful.
I think to One Stop Clinic is an excellent idea and would strongly recommend it
Excellent experience all round. No complaint at all. Very happy
We feel this a god send, all in one day & you know where you are going.
Great members of staff, Betty was our named nurse, on her first day in this unit. Well done Betty.
Treated with absolute respect and care VERY informed and was able to understand everything
You made me feel like "Bill" not just another patient. Thank you!!!
Made sure all options are laid out in normal language.
Made sure fully aware of side effects!
Absolutely brilliant and excellent idea. Everyone has done their job
Can't say a bad word about the experience
From walking in very well Looked after. Felt at ease. All nurses very friendly and informative. Refreshments Provided. Was
Very good. Thank-you
I have been treated very well, I would like to thank everybody involved in my care
It was good to see everyone in the one visit, but some people may struggle with too much information to take in
All staff brilliant
The care received has been efficient, all within a timely manner.
We have felt supported and the members of staff with we have interacted with have all been lovely.
Seeing all the relevant specialists within one appointment, albeit a long one, is much better than going back and forward
I found seeing everyone in one clinic very encouraging and very helpful
I really enjoyed the great support from every person I met and engaged with
It was truly a really good experience thank you all so very much for your help and support

6. Summary & Conclusions

- Successful implementation of a new model of cancer treatment care
- Immediate & substantial pathway improvements at 50% capacity (1x clinic per week)
- Median wait from treatment referral to a decision to treat has reduced from 35 days to 7 days. A median saving of 28 days and no patient waiting more than 18 days (previous longest wait 179 days)
- A decision to treat is made on the day of clinic, in complex lung cancer care in 86%
- Substantial benefits from holistic care and optimisation
    - 94% uptake of tobacco dependency treatment
    - Integrating Prehab4cancer into the clinic has increased uptake from 37% to 95%
    - Nutritional & frailty optimisation
- Delivered in a supportive environment, providing information in an understandable way enabling satisfaction in decision making and an exceptional experience of care

There are additional benefits that include the professional satisfaction for the staff involved in this clinic. The role of the CNS has been enriched with the team playing a more active role in MDT and overall, there has been positive feedback from all the workforce.

7. Next steps

Existing One Stop Clinic service. The opening of a second clinic per week will lead to yet further pathway improvements. Formal launch of the second clinic is planned for March 2023 with an interim measure of 2x clinics on alternate weeks from December 2022.

Ongoing refinement and quarterly reviews will be undertaken.

One stop lung cancer clinics as a model of care**.** The benefits of the holistic care (CURE, prehab4cancer, Oncogeriatrics, St Ann's Hospice) with the one-stop clinic for patients is unquestionable. The GM Lung Cancer Pathway Board will review the service provision for patients whose MDT outcome is to directly be assessed by surgery or oncology and how they might be able to benefit from a similar service. It is also likely to be a model of care for locally advanced lung cancer requiring multi-modality treatment and to deliver new neo-adjuvant surgical pathways.

A model of care for cancer pathways? The interim results of this clinic demonstrate a clear benefit to patients in terms of quality, and experience. It is felt that this model would suit other specialities where there are high risk or complex patient cohorts. Part of the overall service evaluation should include scalability across GM services, and scalability for lung cancer services outside of Greater Manchester.

Full Service Evaluation. As part of the funding arrangement a full evaluation of the two-year project will be undertaken, to additionally include a value for money assessment and recommendations for the future of the lung clinic service.

Definitions / Methodology

Pre-clinic cohort.

Prior to the launch of the clinic, a review of all patients going through lung cancer MDTs identified 29 patients who met the criteria for the one stop clinic, who would have been invited to the one stop had the service been in operation. This has allowed an interim real-world comparison against the first 59 to benefit from the one stop clinic.

Referral Acceptance

Following the Lung SMDTs decision to refer to One Stop, patients are DRP'd to the one stop clinic. The patient's pathway remains the responsibility of the first seen Trust at this point until a DTT is agreed with the patient (in the same way as if a dual referral was made). The referral acceptance date is the date the referral is triaged by a consultant and accepted at MFT. Referrals are triaged within 1 working day of receipt. For the referral to be accepted, it must contain all required information to ensure a treatment decision can be made. To ensure this is consistently done, Greater Manchester has minimum standards for lung cancer referrals that all referring teams adhere to (https://gmcancer.org.uk/wp-content/uploads/2022/09/GM-Lung-Cancer-Referrals-SOP-v2-Approved-June-2020.pdf).

Referral Acceptance (one stop) to DTT compared with pre-clinic cohort comparison

This compared the 59 patients that have been through the one stop using the date the referral was accepted as Day 0 and the date of the DTT compared to the date of the SMDT for the 29 pre-clinic cohort as Day 0 to DTT.

Referral Acceptance (one stop) to treatment compared with pre-clinic cohort comparison

This compares the 54 patients that have been through the one stop using and have completed their treatment by calculating the date the referral was accepted as Day 0 and the date of the FDT (first definitive treatment) compared to the date of the SMDT for the 29 pre-clinic cohort as Day 0 to their FDT date.

Appendix 1

One-stop lung cancer clinic - service over vi

Appendix 2

GM Lung Cancer Performance Improv

Please see separate attachments for Appendix papers 1 & 2