

Oesophago-gastric Cancer Pathway Board Annual Report 2014/15

Pathway Clinical Director: Mr Jonathan Vickers
Pathway Manager: James Leighton

Executive summary

The Oesophago-gastric (OG) pathway board is now a well-established and highly functioning board. It continues to enjoy a representation from all stakeholders and since the 2013/14 report has identified a patient and primary care representation for the group.

Over the last 12 months the board has been responsive, positive and constructive and will look to build on these behaviours over the next 12 months.

However a number of challenges for the board remain. The most significant being, that it has been meeting during a period of anticipated reconfiguration. Whilst the board has not allowed this to distract them from their work, the board feels that they could achieve much more if the service was more effectively structured.

As the planned service procurement has been postponed and any future service reconfiguration will be set against a background of a developing Devolution Manchester, the board feel that they are well placed to support the commissioners as an effective clinical body and look forward to undertaking this.

Over the last 12 months the board has largely focussed on standardising the provision of Oesophago-gastric oncology across the conurbation. This year it has successfully –

- Agreed a common pathway for all patients, thus replacing the previous three
- Developed and implemented diagnostic OG pathology guidelines
- Developed and implemented diagnostic OG Radiology guidelines including a common reporting template
- Developed and implemented a protocol for the diagnosis and management of patients diagnosed with low grade dysplasia
- Successfully obtained funding to pilot a pre and post-surgery fitness programme for Salford residents who are patients and undergoing treatment

The board are proud of this output as there has also been extensive consultation with all relevant stakeholders to ensure that there is collective acceptance and implementation of this work.

Looking forward to the next 12 months the focus of the board will be on supporting any service reconfiguration by acting as an expert panel and an effective clinical body.

They feel that the work undertaken so far in standardising the service has complemented this aim but feel that they now need to develop a number of service standards that could be used to define any future commissioned service.

On a related issue the board will agree the outcome measures or outputs that will be used to assess and monitor the service effectiveness along the whole pathway. This is a multi-organisation project and particularly challenging as the available data is not easily accessible.

This work will allow better planning to support patients and carers better in living with and beyond their disease by getting a deeper understanding of the non-surgical elements of the pathway and designing appropriate supportive measures.

The board also will seek this year to agree a common follow-up process for all providers that ensures that patients are seen in the appropriate location by the appropriate professional at the appropriate time. As part of this work it will assess the possibility of establishing joint surgical and oncology clinics to benefit patients.

The board will also in the next 12 months undertake a patient experience survey in the absence of the national cancer patient experience survey. This will be done in collaboration with the currently established OG patient support groups.

The board this year actively supported the “Be clear on cancer” OG campaign run by NHS England. It intends to continue to support the agenda of the detection, prevention and awareness cross cutting group in whatever way it can. The board sees this as a key function and one that it looks forward to undertaking.

In summary, in the coming year the board has identified four key objectives, these are –

- Provide the required level of support to the commissioning process to ensure an effective and IOG compliant service is established
- Set service standards that will help define a future commissioned service
- Agree the key clinical outcomes and outputs that will begin to better assess service effectiveness
- Review and standardise the follow up process across Greater Manchester and East Cheshire

The work of the board will not be limited to just these objectives. As the year unfolds new challenges and opportunities will be identified. The board feel that as a high quality, dedicated, functioning group they are adaptable and capable of accepting and addressing all possibilities to deliver the objectives of Manchester Cancer.

The board are rightly proud of their achievements over the past twelve months and thank everyone who played a part in this success for their support and commitment.

Introduction – the Pathway Board and its vision

This is the annual report of the Manchester Cancer Oesophago-gastric cancer Pathway Board for 2014/15. This annual report is designed to:

- Provide a summary of the work programme, outcomes and progress of the Board – alongside the minutes of its meetings, its action plan and its scorecard it is the key document for the Board.
- Provide an overview to the hospital trust CEOs and other interested parties about the current situation across Manchester Cancer in this particular cancer area
- Meet the requirements of the National Cancer Peer Review Programme
- Be openly published on the external facing website.

This annual report outlines how the Pathway Board has contributed in 2014/15 to the achievement of Manchester Cancer's four overarching objectives:

- Improving outcomes, with a focus on survival
- Improving patient experience
- Increasing research and clinical innovation
- Delivering compliant and high quality services

1.1. Vision

The overwhelming issue for the board over the next twelve months will be reconfiguring the service across Greater Manchester and East Cheshire. This year the board has helped to standardise the existing services by developing a common pathway and a number of common protocols and guidelines.

Over the next 12 months it sees its role as one of supporting any reconfiguration by helping to define the service and setting standards that take the new service beyond just achieving IOG compliance. As well as being the focal point for patient and clinical engagement with the commissioning process.

The board accepts the challenge of early detection and prevention of the disease. It also sees itself as the body to exploit innovation, provide quality assurance of the pathway and be responsible for enhancing the experience of those living with and beyond their cancer.

The board will deepen its knowledge base and understanding of the whole pathway and put in place actions where the patient outcomes, survival rates and experience can be improved and enhanced.

1.2. Membership

Trust	Nominee	Profession/ specialty
SRFT	Jonathan Vickers	Chair
	Colin Jackson	Patient representative
Bolton	Dr Amanda Law	Consultant Radiologist
	Dr David Bisset	Consultant Histopathologist (Retiring July 2015)
	Mr Joseph Varghese	Consultant Surgeon
Christie	Dr Lubna Bhatt	Clinical Oncology
	Dr Richard Hubner	Medical Oncology
CMFT	Mr Alan Li	Consultant upper GI surgeon
	Dr Rob Willert	Consultant Gastroenterologist
East Cheshire	Dr Konrad Koss	Consultant Gastro-enterologist
Pennine	Julie Wolfenden	CNS
	Dr Regi George	Consultant Gastro-enterologist
SRFT	Miss Rachel Melhado	Consultant OG surgeon
	Mrs Michelle Eden-Yates	Lead OG CNS
	Dr. Stephen Hayes	Consultant histopathologist
Stockport	Louise Porritt	CNS
Tameside	Mr Abduljalil Benhamida	Consultant Upper GI surgeon
UHSM	Andrew Macdonald	Consultant OG Surgeon
	Tina Foley	Lead UGI CNS
	Dr. Sue Liong	Radiologist
WWL	Dr R Keld (Cover Dr P Begum)	Consultant Gastroenterologist
	Ann Anderton (Cover Chris Peel)	Upper GI Cancer Nurse Specialist
Wigan CCG	Dr Liam Hosey	GP representative

1.3. Meetings

The pathway board met four times in 2014 and has met twice in 2015. The board have scheduled four subsequent meetings in 2015. Below are the dates of the pathway board meetings and the links to the board minutes.

25th April 2014

<http://manchestercancer.org/wp-content/uploads/2014/09/OG-Pathway-Board-Meeting-Minutes.pdf>

27th June 2014

<http://manchestercancer.org/wp-content/uploads/2014/09/OG-Pathway-Board-Meeting-Minutes-.pdf>

3rd October 2104

<http://manchestercancer.org/wp-content/uploads/2014/09/OG-Pathway-Board-Meeting-Minutes3.pdf>

28th November 2104

<http://manchestercancer.org/wp-content/uploads/2014/09/OG-Pathway-Board-Meeting-Minutes4.pdf>

30th January 2014

<http://manchestercancer.org/wp-content/uploads/2014/09/OG-Pathway-Board-Meeting-Minutes5.pdf>

27th March 2014

<http://manchestercancer.org/wp-content/uploads/2014/09/OG-Pathway-Board-Meeting-Minutes6.pdf>

Holding board meetings within working hours will always be a challenge for clinical staff. However overall attendance has been pretty consistent and where non-attendance has been an issue the Pathway director has addressed it on a personal level.

The record of the attendance at each meeting to-date is in appendix 1.

In early 2015 the board has also, in collaboration with the Colorectal and HPB boards, supported a GP study day on upper and lower digestive tract oncology held at University Hospital of South Manchester.

At this point in time the board is waiting for the cancer education strategy to be developed by Manchester Cancer, before finalising its own educational strategy.

However, in collaboration with Central Manchester NHS Foundation Trust, by the end of the year the board will support a clinical study day in OG cancers to support doctors in training.

2. Summary of delivery against 2014/15 plan

No	Objective	Alignment with Provider Board objectives	Tasks	By	Status Green = achieved Amber = partially achieved Red = not achieved
1	To optimise data collection to allow the generation of meaningful outcome measures.	Objective no 1	Identify data sources		
			Access & analyse data		
			Review and propose new measures		
			Report outputs to Board		
2	To standardise the OG cancer pathway	Objective no 4			
3	To standardise the follow-up process Greater Manchester and east Cheshire to allow efficient and effective patient care.	Objectives 3 and 4	Completed a review of follow-up provision		
			Draft a FU protocol		
			Consult with stakeholders		
			Undertake an impact assessment		

3. Improving outcomes, with a focus on survival

3.1. Information

Oesophageal cancer is the thirteenth most common cancer in the UK. In 2011, around 8,300 people were diagnosed with Oesophageal cancer in the UK, that's 23 people every day. Oesophageal cancer is the eighth most common cancer in men in the UK, with around 5,600 new cases diagnosed in 2011 and the fourteenth most common cancer in women with 2,800 women were diagnosed.

More than 8 in 10 Oesophageal cancers occur in people aged 60 or over. Oesophageal cancer rates have risen by 65% in men and 14% in women since the mid-1970s.

Younger Oesophageal cancer patients have better survival rates than older patients. Overall, around 40% of people diagnosed with Oesophageal cancer survive the disease for at least one year after diagnosis.

Around 13% of people diagnosed with Oesophageal cancer survive the disease for at least five years after diagnosis. Ten year survival for Oesophageal cancer has trebled in the last forty years but it is still low. Around 1 in 10 patients are likely to survive their disease for at least ten years.

In 2011 in the UK, around 7,100 people were diagnosed with stomach cancer, that's more than 19 every day. Stomach cancer is the eleventh most common cancer in men in the UK with around 4,600 new cases in 2011. In the same period 2,500 women in the UK were diagnosed, making it the 15th most common cancer in females.

Around 9 in 10 new cases of stomach cancer occur in people aged 55 and over. Stomach cancer incidence rates in Britain have more than halved since the late 1980s.

Over the last 40 years five-year relative survival rates for stomach cancer have tripled. However Stomach cancer survival rates remain low with less than one in five people surviving the disease for five years or more.

3.2. Progress

The board has this year, under the direction of Miss Melhado (Data Lead), started the process of auditing 1 year survival rates for patients with OG cancer. This will also include data from the Christie for those patients on a non-surgical pathway.

3.3. Challenges

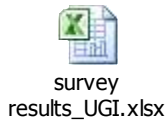
The biggest challenge to reporting on the survival rates has been getting access to Trust data for their cohort of patients. This is a consequence of working in an organisationally competitive network. It is anticipated that this challenge will be addressed by the eventual reconfiguration of the service.

4. Improving patient experience

4.1 Information

The 2104 National Cancer Patient Experience Survey for upper GI cancer patients had 190 respondents from Greater Manchester and of these 149 came from the four treating Trusts. (i.e. SRFT, CMFT, UHSM & the Christie).

The report from the 2104 National Cancer Patient Experience Survey for upper GI cancer patients can be found in the embedded document below.



For the 8 questions identified as key indicators the response for upper GI is as follows –

- Q12 Patient felt they were told sensitively that they had cancer
- Q20 Patient definitely involved in decisions about care and treatment
- Q22 Patient finds it easy to contact their CNS
- Q25 Hospital staff gave information about support groups
- Q65 Hospital and community staff always worked well together
- Q67 Given the right amount of information about condition and treatment
- Q69 Patient did not feel that they were treated as a 'set of cancer symptoms'
- Q70 Patient's rating of care 'excellent' / 'very good'

	Q12	Q20	Q22	Q25	Q65	Q67	Q69	Q70
National average - total	84%	72%	73%	83%	63%	88%	81%	89%
National average - UGI	81%	71%	74%	83%	61%	88%	79%	89%
Manchester Cancer - UGI	77%	71%	72%	84%	59%	89%	78%	87%

4.2 Progress

This feedback has been reviewed by the board at several meetings and the board are planning to undertake a local OG specific survey over the next 12 months.

4.3 Challenges

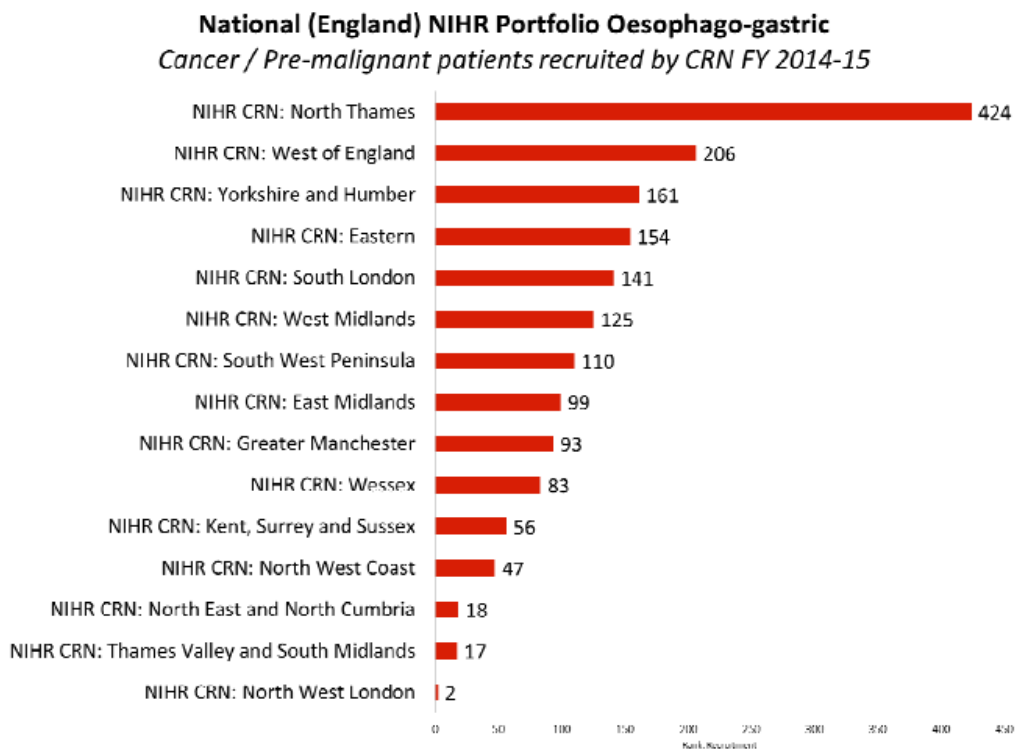
It is difficult to draw any firm conclusions as this analysis is for all patients with cancer of the upper gastro-intestinal tract, which means that the Hepato-biliary cancer patients are also included and it is not possible to differentiate the responses from the two disease types.

Therefore the board intend to undertake a local OG specific survey over the next 12 months to better inform them on this objective.

5. Increasing research and innovative practice

5.1 Information

Over 2014/15 the number of OG patients recruited into trials when compared nationally is as follows -



The recruitment by Trust over this period is below –

Study Design	Acronym	Salford Royal	The Christie	UHSM	Grand Total
Interventional	BioStent		1	1	1
Interventional	FACING		2	2	2
Interventional	GO2		1	1	1
Interventional	NCRN366: Rilotumumab + ECX in 1st line c-Met Gastric or Gastroesophageal Junction Adenocarcinoma		7	7	7
Interventional	NCRN369: GATSBY TDM1 vs taxane in previously treated advanced HER2+ gastric ca		4	4	4
Interventional	NCRN635 - LJM716 with BYL719 compared to taxane or irinotecan in esophageal cancer		1	1	1
Interventional	NeoSCOPE: Neoadjuvant - Study of Chemoradiotherapy in OesoPhagEal Cancer		1	1	1
Interventional	ROCOCO: Radiotherapy & olaparib for oesophageal carcinoma		5	5	5
Interventional	ST03		17	17	17
Interventional Total			39	39	39
Observational	OCCAMS: Multicentre Study Determining Predictive Biomarkers & Targets for Oesophageal Adenocarcinoma	44		10	54
Observational Total		44	10	54	54
Grand Total		44	39	10	93

5.2 Progress

Recruitment into clinical trials is a standing item on the agenda of each board meeting and the board reviews the recruitment levels within each organisation.

Dr Hubner, as research lead, has asked the NIHR for some more detail specifically in year on year changes and volumes of eligible patients.

5.3 Challenges

The three MDTs are very active in clinical research at a local level and regularly present and publish research. Some studies require very challenging streamlining of patient pathways to meet tight study timelines, and all the MDT functions cohesively to deliver this.

Recruitment relies not just on offering and conducting trials, but on having trials to offer. The MDTs and the board will do all they can to engage with Sponsors to ensure that all possible industry-sponsored and NCRN portfolio studies are available to the patients of Greater Manchester and East Cheshire, and that all suitable patients are considered for trial entry.

The board feel that the key to successful clinical research recruitment is that there is a co-ordinated front to the participation and will work to achieve that end.

6 Delivering compliant and high quality services

6.1 Information

Primary care practitioners will refer all patients defined by the “urgent, suspicious of cancer” guidelines for Oesophago-Gastric cancer to the contact point of a single named diagnostic or local team.

Local Oesophago-gastric teams provide local care for their own catchment area and collaborate on clinical decisions within sector-based MDTs with a full core complement of specialists. Patients will be treated in their own locality or at a specialist treatment centre, according to the decision of the MDT and by the appropriate specialist member of the MDT, in discussion with the patient.

The specialist Oesophago-Gastric Cancer teams and their catchment populations are as follows –

Specialist Oesophago-Gastric Cancer Teams	SMDT Lead Clinician	Referring MDTs	Catchment Population
Central Manchester University Hospital Foundation Trust	Mr Alan Li	Central Manchester (including Trafford) Stockport Tameside	452,291 301,096 241,875
			995,262
Salford Royal NHS Foundation Trust	Miss Laura Formela	Salford Pennine Bolton Wigan	253,112 856,830 297,958 321,084
			1,728,984
University Hospital of South Manchester NHS Foundation Trust	Mr Andrew MacDonald	South Manchester East Cheshire	168,678 204,353
			373,031
TOTAL			3,097,277

*Figures from <http://www.england.nhs.uk/wp-content/uploads/2013/12/ccq-allocation-big-table-v2.pdf>

The Christie Hospital is the tertiary referral centre for the region. Radiotherapy is delivered at Christie Hospital and the satellite radiotherapy units based at Royal Oldham Hospital and Salford Royal.

Some chemotherapy and clinical trials will continue to be delivered from Christie Hospital, although local chemotherapy is currently available at:

- Wigan
- Bolton
- Oldham
- East Cheshire
- Mid Cheshire

This OG service in greater Manchester and East Cheshire remains non IOG compliant and this has been an historical problem in existence during the life time of the previous cancer network.

It was anticipated that in the 2015/16 financial year a specialised commissioner led procurement would take place that would lead to a single service and thus address this issue. However this has been postponed and will now be locally led as part of the Manchester Devolution exercise.

In light of this the board has worked hard at standardising the existing service where possible and intends to provide support as required to any forthcoming commissioning process.

6.2 Progress

The board has over the last year developed and implemented the following with the associated links attached –

Common OG cancer pathway

<http://manchestercancer.org/wp-content/uploads/2014/09/OG-Pathway-2015.pdf>

OG cancer radiological guidelines

<http://manchestercancer.org/wp-content/uploads/2014/09/OG-Radiology-Guidelines-2015.pdf>

OG cancer pathology guidelines

http://manchestercancer.org/wpcontent/uploads/2014/09/revised_pathology_UGI_guidelines_final1.pdf

Protocol for the diagnosis and management of patients diagnosed with low grade dysplasia

http://manchestercancer.org/wp-content/uploads/2014/09/LGD_Barretts_Algorithm_OG_Cancer_Board_20151.pdf

6.3 Challenges

Asking the board to take forward the OG cancer agenda whilst the whole service is in a state of flux was always a going to be challenge and one that the board has risen to. The cancellation of the proposed procurement has added a layer of complexity to that challenge.

The board will therefore take a proactive role in supporting any new commissioning process and support the commissioners to ensure a successful outcome for the patients of Greater Manchester and East Cheshire.

7 Objectives for 2015/16

The board has identified the following seven objectives for 2105/16 -

1. Develop service standards the help define the service
2. Organise an open meeting
3. Agree the key clinical outcomes and outputs that will begin to define the service
4. Standardise the follow up process across Greater Manchester and East Cheshire
5. Assess the feasibility of introducing joint surgical and oncology out-patient clinics
6. Participate in a clinical study day
7. Work with provider Trusts to co-ordinate a response to the “suspected cancer : recognition and referral” NICE guidelines

The work of the board will not be limited to just these objectives. As the year unfolds new challenges and opportunities will be identified.

The board feel that as a high quality, dedicated, functioning group they are adaptable and capable of accepting and addressing all possibilities to deliver the objectives of Manchester Cancer.

8 Appendix 1 – Pathway Board meeting attendance

ATTENDANCE 2014 - PATHWAY BOARD MEETING

OG

NAME	ROLE	TRUST	25/04/2014	27/06/2014	03/10/2014	28-Nov-14	30/01/2015	27/03/2015
Dr Amanda Law	Consultant Radiologist	Bolton	Apologies	✓	✓	✓	✓	Apologies
Dr David Bisset	Consultant Histopathologist		✓	Apologies	Apologies	✓	Apologies	Apologies
Mr Joseph Varghese	Consultant Surgeon		Apologies	✓	Apologies	Apologies	✓	Apologies
Dr Lubna Bhatt	Clinical Oncology	Christie	✓	✓	✓	✓	Apologies	✓
Dr Richard Hubner	Medical Oncology		✓	✓	✓	Apologies	✓	✓
Mr Alan Li	Consultant upper GI surgeon	CMFT	✓	Apologies	Apologies	✓	Apologies	Apologies
Dr Rob Willert	Consultant Gastroenterologist		✓	✓	✓	✓	Apologies	✓
Dr Konrad Koss	Consultant Gastroenterologist	East Cheshire	✓	Apologies	✓	✓	Apologies	✓
Dr R George	Gastroenterology	Pennine	Apologies	✓	Apologies	Apologies	✓	
Mr S Senapati	Surgeon		✓	✓	Apologies	Apologies	Apologies	Apologies
Mr J Vickers	Pathway Director	SRFT	✓	✓	✓	✓	✓	✓
Miss Rachel Melhado	Consultant OG surgeon		✓	✓	✓	✓	✓	✓
Mrs Michelle Eden-Yates	Lead OG CNS		✓	Apologies	Apologies	✓	✓	Apologies
Dr. Stephen Hayes	Consultant histopathologist		✓	✓	✓	✓	✓	✓
Louise Porritt	CNS	Stockport	✓	✓	✓	Apologies	✓	Apologies
Colin Jackson	Patient representative				✓	✓	Apologies	✓
Mr Abduljalil Benhamida	Consultant Upper GI surgeon	Tameside	Apologies	✓	✓	✓	Apologies	Apologies
Andrew Macdonald	Consultant OG Surgeon	UHSM	✓	✓	✓	Apologies	Apologies	Apologies
Tina Foley	Lead UGI CNS		✓	Apologies	Apologies	Apologies	Apologies	✓
Dr Sue Loing	Consultant Radiologist	UHSM			✓	✓	✓	Apologies
Dr R Keld (Cover Dr P Begum)	Consultant Gastroenterologist	WWL	✓	✓	Apologies	✓	Apologies	Apologies
Ann Anderton (Cover Chris Peel)	Upper GI Cancer Nurse Specialist		✓	Apologies	Apologies	Apologies	Apologies	✓
Dr Liam Hosey	GP representative	Wigan CCG				Apologies	Apologies	Apologies

9 Appendix 2 – Pathway Board Annual Plan 2015/16

10 Oesophago-Gastric Pathway Board Annual Plan 2014-15

Pathway Clinical Director:	Mr Jonathan Vickers
Pathway Board Members:	
Pathway Manager:	James Leighton
Date agreed by Pathway Board:	31st July 2014
Date agreed by Medical Director:	
Review date:	January 2016

Summary of objectives

No	Objective	Alignment with Provider Board objectives
1	Develop service standards the help define the service	Objectives 1 & 4
2	Widen stakeholder engagement by holding an open meeting	Objectives 3 and 4
3	Confirming the key clinical outcomes to be measured for Oesophago-gastric cancer	Objectives 1 & 3
4	Standardise the follow up process across Greater Manchester and East Cheshire	Objectives 1 & 3
5	Assess the feasibility of introducing joint surgical and oncology out-patient clinics	Objective 1 & 3
6	Support and participate in a clinical study day	Objectives 1 & 4
7	Work with provider Trusts to co-ordinate a response to the “suspected cancer : recognition and referral” NICE guidelines	Objective 1

Objective 1:

Objective:	To develop service standards the help define and govern the service
Rationale:	As part of the intended reconfiguration of Oesophago-gastric oncology surgery in Greater Manchester it is proposed that the provision is governed by a single service that may be located in a number of provider organisations. Having agreed and set standards for this service will drive the service forward and prevent variance between sites.
By (date):	December 2015
Board measure(s):	To have an agreed number of standards that will be used to govern the single service
Risks to success:	Time and other commitments of involved personnel Resources Mitigation: Aim for an efficient, unified, sustainable approach.
Support required:	Support at executive level for the organisational change process

Work programme		
Table the discussion at July board meeting	PD	Jul 15
Agree a working party tasked to draw up the standards	Board	Jul 15
Draft service standards	Working group	Sep 15
Agreed by the board	Board	Jan 15

Objective 2:

Objective:	To widen the level of stakeholder engagement
Rationale:	The board wishes to engage better with the breadth of staff providing care for patients diagnosed with Oesophago-gastric cancers. This would include secondary and primary care staff as well as service user and care groups.
By (date):	December 2015
Board measure(s):	That the board will hold an open meeting that all stakeholder sin urological care will be invited
Risks to success:	Time and other commitments of involved personnel Resources
Support required:	Executive support as identified and required

Work programme		
Board to agree meeting schedule	Board	Jul 15
Venue to be booked	PM	Jul 15
Meeting advertised to stakeholders and wider	PM	Jul 15
Meeting to be held	Board	Sep 15

Objective 3:

Objective:	Confirming the key clinical outcomes to be measured for Oesophago-Gastric cancer
Rationale:	The generation of meaningful outcome measures to facilitate national and international comparison, and year on year comparison of our own outcomes. This will ensure that the patient care delivered compares favourably with other centres and identify areas where care might be improved.
By (date):	31/3/16
Board measure(s):	The ability to generate outcome figures for 1 and 2 year survivals without additional task-specific audit
Risks to success:	Time and other commitments of involved personnel Mitigation: Aim for an efficient, unified, sustainable approach
Support required:	Recognition and protection of the vital role of existing data managers. Reflection in job-planning and appraisal of the effort and commitment of clinicians in generating this data

Work programme		
Draft list of outcome measures tabled at board meeting	Board	5 9 15
Final list of outcome measures agreed	Board	7/11/15
Full commencement of routine data collection	Board	1/1/16
Audit of completeness of data collected	Board	31/3/16

Objective 4:

Objective:	To standardise the provision follow up clinics for patients diagnosed with Oesophago-gastric cancer
Rationale:	The board are keen that all patients receive the same high level of care, irrespective of their treating hospital. Standardisation of how patients are safely followed-up post treatment will help deliver this objective.
By (date):	31 march 2016
Board measure(s):	Review of current follow up processes and recommendations to the commissioners on the optimum follow-up arrangements for clinically appropriate patients. Increased patient satisfaction, more new appointment slots as follow-up slots are converted
Risks to success:	Time and other commitments of involved personnel. The single service is not established.
Support required:	Support at executive level for organisational change process

Work programme		
Review current follow-up processes	Board	Jul 15
Agree a position statement on follow-up clinics	Board	Sep 15
Draft possible follow-up protocols	Board	Jan 16
Agree follow-up processes	Board	Mar 16

Objective 5:

Objective:	To assess how feasible it would be to run joint surgical and oncological clinics across the conurbation
Rationale:	Currently those patients that are required to see a surgeon and an oncologist do so on different dates and in different locations. By running joint clinics it is hoped that the decision making will become more streamlined and lead to a better outcome and patient experience.
By (date):	Mar 16
Board measure(s):	The board will have produced an impact assessment with outline costings
Risks to success:	Time and other commitments of involved personnel Lack of data sharing by organisations
Support required:	Executive support as identified and required

Work programme		
Agree objectives at Board	PD	Jul 15
Undertake review of similar provision locally and nationally	PM	Dec 15
Provide an impact assessment to the board	PD / PM	Mar 16
Agree policy based on the assessment undertaken	Board	Mar 16

Objective 6:

Objective:	To support the clinical workforce by the delivery of training and education in Oesophago-gastric cancer
Rationale:	There will always be a need to maintain the understanding and competency of the Oesophago-gastric cancer clinical workforce. The board are keen to support this to ensure that our patients are cared for by staff with the correct level of expertise and experience.
By (date):	Dec 15
Board measure(s):	Board members will have helped design and deliver a clinical study day for the staff working in Oesophago-gastric cancer care.
Risks to success:	Time and other commitments of involved personnel
Support required:	Reflection in job-planning and appraisal of the effort and commitment of clinicians in generating this data

Work programme		
Agree meeting date and level of participation required	PD	Jul 15
Design and plan study materials	Board	Sep 15
Deliver learning opportunity	Board	Dec 15

Objective 7:

Objective:	Work with commissioner and provider organisations to co-ordinate a response to the “suspected cancer: recognition and referral” NICE guidelines.
Rationale:	This guidance has asked for better more direct access for primary care in referring patients suspected of cancer. The full implication of this guidance for providers, service users and commissioners needs to be better understood.
By (date):	Dec 2015
Board measure(s):	Review of guidance and a protocol written to support delivery of the guidance
Risks to success:	Time and other commitments of involved personnel Resources Mitigation: Aim for an efficient, unified, sustainable approach.
Support required:	Support at executive level for organisational change process

Work programme		
Review of guidance and identify needs / primary care access	PM	Q2
Liase with commissioners to understand possible volumes	PD	Q2
Assess impact and possible solutions	PD/PM	Q3
Review at board	Board	Nov 15
Develop protocol to ensure correct patients access scanning	Board	Jan 16