Manchester Cancer

# Systemic therapies Pathway Board

## Annual Report 2013/14

Pathway Clinical Director: Professor Gordon Jayson
Pathway Manager: James Leighton

**Version 1.3**

## Executive summary

The Systemic anti-cancer therapy (SACT) pathway board has only been in existence since its first meeting on 28th April and has only met once since then. The attached report and work plan reflects this timescale.

The board has been responsive, positive and constructive and will look to build on this work plan with over the next 12 months.

The board has faced a number of challenges in its first 4 months. The most significant being, that there is a lack of good quality data with which to inform the board on patient outcomes and survival.

It has been constituted at a time when the lead provider has also a well-established Chemotherapy delivery group, whose agenda overlaps somewhat with the pathway board agenda. To address this, the board has agreed to regular joint meeting with this group.

Also, currently there is no patient or GP representative on the board. The board are keen that this is resolved in the near future and will work with Manchester cancer to address this issue and then put in place appropriate supportive measures for the patient representative.

However even with this short time period it has made good progress such as the following –

- Established the board and begun a strategic planning process
- Identified opportunities to re-design the workforce
- Submitted a research funding proposal to support delivery of clinical trials in remote sites
- Begun a number of SACT delivery sites visits to better understand front line services
- Established joint meetings with the Christie Chemotherapy delivery group

As part of the on-going work plan the board will devise and agree the outcome measures or outputs that will be used to assess and monitor the patient and carer experience along the SACT pathway. This will be addressed as part of this year's action plan.

In the coming year the board has set three objectives –

- Improved data collection to generate outcome data
- Increase the number of non-medical prescribers within SACT units
- Development of research nurses within SACT delivery site

# 1. Introduction

2013/14 was a transitional year for cancer services in Greater Manchester and East Cheshire. The Greater Manchester and Cheshire Cancer Network ceased to exist in March 2013 when cancer networks nationally were amalgamated into strategic clinical networks as part of the NHS reorganisation. In Greater Manchester this coincided with the creation of Manchester Cancer, an integrated cancer system for Greater Manchester and East Cheshire.

Twenty Manchester Cancer Pathway Clinical Directors were appointed in late 2013 and took up their roles on 1st January 2014. They spent the first months in post forming their Pathway Boards, which are multi-professional clinical groups from across the region. These pathway Boards are now formed and most had their first meeting in April/May of 2014.

As such, this is a transitional annual report. It outlines the current configuration of services, the progress in forming the Pathway Board, the data on outcomes and experience that the Board took into account when setting its objectives, and what those objectives are for 2014/15 and beyond. In July 2015 every Manchester Cancer Pathway Board will publish a full annual report, outlining the work of its first full year and its progress against those objectives.

This annual report is designed to:

- Provide a summary of the work programme, outcomes and progress of the Board. Alongside the minutes of meetings, the action plan and 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 website.

# 2. General overview

Systemic anti-cancer therapy (SACT) or chemotherapy is a category of cancer treatment that uses one or more anti-cancer drugs that are given as part of a standardized regimen. SACT regimens may be given with curative intent, with the aim of prolonging life or to reduce symptoms. SACT, which includes hormonal and targeted therapies, is one of the principal therapeutic modalities, alongside surgery and radiotherapy, for the treatment of cancer.

In England in the period from June 2013 until May 2014 149,524 patients received 242,045 regimens and 645,490 cycles of SACT treatment.

In the same period in the Greater Manchester and East Cheshire area 9378 (6.2% of England total) patients received SACT, including 13,046 courses comprising 35,148 cycles of treatment.

http://www.chemodataset.nhs.uk/reports/

## 3. Background to the cross-cutting area

The work of the recently established pathway board was previously carried out by the Greater Manchester & Cheshire Cancer Network Chemotherapy Group. This was a multi-professional group made up of health professionals from all organisations across the Greater Manchester and Cheshire Cancer Network. It was chaired by Mr Geoff Saunders, Consultant Pharmacist at the Christie NHS Foundation Trust.

The purpose of the CCG was that on behalf of the Network Management team and Board, it:
- Advised the Cancer Network Board and Clinical Advisory Group on issues relating to chemotherapy
- Consulted with Network Clinical Subgroups (CSGs) on the chemotherapy aspects of clinical and referral guidelines
- Ensured co-ordination across the Network in implementing the NICE guidance on applicable drugs used in oncology
- Ensured co-ordination and consistency across the Network for implementing the National Chemotherapy Standards
- Ensured co-ordination and consistency across the Network in the work of the local cancer chemotherapy group
- Oversaw the work of the Network Oncology Pharmacists group.
- Oversaw the work of the Network Nurses Group
- Ensured the recommendations of National Cancer Advisory Group were implemented across the network

Due to the transition from the Cancer Network to the strategic clinical network and the establishment of Manchester Cancer, the group did not met during 2013-14 and so did not develop a work plan.

## 4. Configuration of services

The pathway board co-ordinates the delivery of systemic anti-cancer therapy (SACT) over an area covering a population of approximately 3.2 million.

The Christie NHS Foundation Trust is the tertiary referral centre for the area. Currently this is the central location for the delivery of systemic therapies and clinical trials. There is delivery of therapies at remote centres through the area and served by the following organisations:

North West Sector:
Wrightington, Wigan and Leigh NHS Trust
Royal Bolton Hospital NHS Foundation Trust
Salford Royal Foundation Trust

North East Sector:
Pennine Acute Hospitals NHS Trust (Bury, North Manchester, Oldham, Rochdale)
Central Manchester University Hospitals NHS Trust

South Sector:
Trafford Healthcare NHS Trust
Tameside Acute NHS Trust
Stockport Foundation NHS Trust
University Hospital of South Manchester NHS Trust
Christie Hospital NHS Trust
East Cheshire NHS Trust

The centres involved and the volumes of patients and treatments delivered are in table 1.

| NHS England Area Team > Hospital Trust | Number of patients | Number of tumour records | Number of regimens | Number of cycles |
|---|---|---|---|---|
| Bolton NHS Foundation Trust | 535 | 545 | 647 | 1,516 |
| Central Manchester University Hospitals NHS Foundation Trust | 261 | 262 | 309 | 441 |
| East Cheshire NHS Trust | 183 | 192 | 195 | 248 |
| Pennine Acute Hospitals NHS Trust | 597 | 633 | 699 | 1,264 |
| Salford Royal NHS Foundation Trust | 129 | 142 | 195 | 310 |
| Stockport NHS Foundation Trust | 295 | 378 | 398 | 739 |
| Tameside Hospital NHS Foundation Trust | 118 | 118 | 124 | 153 |
| The Christie NHS Foundation Trust | 6,134 | 6,261 | 9,103 | 27,214 |
| University Hospital of South Manchester NHS Foundation Trust | 634 | 724 | 760 | 1,740 |
| Wrightington, Wigan and Leigh NHS Foundation Trust | 501 | 543 | 616 | 1,523 |

**Table 1 Systemic therapies delivered by Manchester cancer Trusts June 2013 – May 2014**
http://www.chemodataset.nhs.uk/reports/

The Christie NHS Foundation Trust has an already established Chemotherapy Delivery Group meeting. Given the volumes of patients and treatments being provided by The Christie this group was established to ensure safe and effective care for patients receiving SACT.

Its remit also overlaps with the pathway board somewhat, in that it is also engaged in delivering more SACT closer to the patient and remote from the patient. As a consequence both groups have agreed to hold joint meetings to work together and deliver this agenda.

Professor Jayson, as Chair of Manchester SACT, has joined the Christie Chemotherapy Delivery Group, the Kite-mark process committee for patient treatment, the regional pharmacists meeting group and the local delivery groups for the above units. He will also be involved in writing the Christie and regional hospital chemotherapy strategy for the next 5 years.

## 5. Clinical guidelines

The Pathway Board has only been in place since spring 2014 and has not yet had the opportunity to review its clinical guidelines and patient pathways. As such, the guidelines created by the previous cancer network group have been adopted until such time as they can be reviewed and updated in the coming year.

All of the relevant documentation remains on the legacy website of the old cancer network www.gmccn.nhs.uk and will be migrated to the Manchester Cancer website over the coming months www.manchestercancer.org.

A full list of active current guidelines and their renewal dates will be produced for the updated constitution of July 2015.

The previous GMCCN Network Chemotherapy Group has developed chemotherapy treatment algorithms for all tumour groups which can be found using the following link on the Christie website (accessed via N3 (NHS) connections only).

These algorithms are updated regularly with the most recent version being available on the intranet site.
**http://nww.christie.nhs.uk/documents/default.aspx?Category=Y&Category1=1**

The user should follow the link above, then under the document database Category Search:

1. Select Policies & Clinical Guidelines
2. From the sub-category 1 drop down menu select Chemotherapy Protocols
3. This gives a selection of potential documents

## 6. Clinical information and outcomes

There is an urgent and critical need to identify sub-regional survival statistics for several cancers so that attention on pathways can be focused on those areas. Although regional statistics are available through the NCIN e-atlas, these do not provide the degree of detail needed for us to concentrate attention in poorly performing areas. This is important because we need to understand whether socio-economic factors, patient education and expectations or service pathways need to be improved or, indeed, if all of these factors contribute to poor regional survival.

Some data, for instance the survival statistics for ovarian cancer, have been analysed and demonstrate superior outcomes for patients treated at the Christie. However, this level of detail is required for the more prevalent cancers (lung, breast and colorectal) according to the area where patients come from. A key goal of this board will be to determine these data and to focus subsequent attention on the causes of inter-regional survival differences.

## 7. Patient experience

As the pathway board has had only one meeting of the constituted board, it is still to devise and agree the mechanism for gathering localised patient feedback. The board will review the national chemotherapy patient experience survey (2013) and use this to develop the means to obtain this level of feedback.

However, it is important to note that The Christie NHS Foundation Trust has conducted patient satisfaction assessments for the hospitals through which it delivers care and these questionnaires have identified high levels of patient satisfaction.

The national chemotherapy patient experience survey does not allow for analysis at a regional level. It can be found at - *http://www.londoncanceralliance.nhs.uk/media/66996/Chemotherapy%20PES%20Results%20England%202013.pdf*

## 8. Research and clinical trials

Cancer care and phase 3 clinical trials are intimately related to each other and it is vital that phase 3 clinical trial activity is protected as care is devolved to the patient's local treatment centre and ultimately augmented. To that end the board will define the target recruitment statistics to phase 3 trials and will seek to provide the support needed to deliver this target in each treatment site. One of the critical issues to address will be the placement of sufficient numbers of research nurses and IT support in each Trust so that this level of research can continue.

**Recent peer review and journal papers published**

- First gram-scale synthesis of a heparin-related dodecasaccharide Hansen SU, Miller GJ, Jayson GC, Gardiner JM. Org Lett. 2013 Jan 4;15(1):88-91.
- Indexed distribution analysis significance improved significance testing of heterogeneous parameter maps for testing of spatially heterogeneous parameter maps: Application to dynamic contrast-enhanced MRI biomarkers. Rose CJ, O'Connor JP, Cootes TF, Taylor CJ, Jayson GC, Parker GJ, Waterton JC. Magn Reson Med. 2013 May 10. doi: 10.1002/mrm.24755.
- Small-molecule-induced clustering of heparan sulfate promotes cell adhesion. Takemoto N, Suehara T, Frisco HL, Sato S, Sezaki T, Kusamori K, Kawazoe Y, Park SM, Yamazoe S, Mizuhata Y, Inoue R, Miller GJ, Hansen SU, Jayson GC, Gardiner JM, Kanaya T, Tokitoh N, Ueda K, Takakura Y, Kioka N, Nishikawa M, Uesugi M. J Am Chem Soc. 2013 Jul 31;135(30):11032-9. doi: 10.1021/ja4018682.
- Tetrasaccharide iteration synthesis of a heparin-like dodecasaccharide and radiolabelling for in vivo tissue distribution studies. Hansen SU, Miller GJ, Cole C, Rushton G, Avizienyte E, Jayson GC, Gardiner JM. Nat Commun. 2013; 4: 2016. doi: 10.1038/ncomms3016.
- Predicting response to bevacizumab in ovarian cancer: a panel of potential biomarkers informing treatment selection. Collinson F, Hutchinson M, Craven R, Cairns DA, Zougman A, Wind T, Gahir N, Messenger M, Jackson S, Thompson D, Adusei C, Lederman J, Hall GD, Jayson GC, Selby PJ, Banks RE. Clin Cancer Res. 2013 Aug 9
- Efficient chemical synthesis of heparin-like octa-, deca- and dodecasaccharides and inhibition of FGF2- and VEGF165-mediated endothelial cell functions. Miller GJ, Hansen SU, Avizienyte E, Rushton G, Cole C, Jayson GC, Gardiner JM. Chem. Sci., 2013,4, 3218-3222
- A phase 1 trial of intravenous 4-(N-(S-glutathionylacetyl)amino) phenylarsenoxide (GSAO) in patients with advanced solid tumours. Horsley L, Cummings J, Middleton M, Ward T, Backen A, Clamp A, Dawson M, Farmer H, Fisher N, Halbert G, Halford S, Harris A, Hasan J, Hogg P, Kumaran G, Little R, Parker GJ, Potter P, Saunders M, Roberts C, Shaw D, Smith N, Smythe J, Taylor A, Turner H, Watson Y, Dive C, Jayson GC; A Cancer Research UK Drug Development Office Phase I clinical trial. Cancer Chemother Pharmacol. 2013 Oct 20.
- Evaluation of hypertension and proteinuria as markers of efficacy in antiangiogenic therapy for metastatic colorectal cancer. Khoja L, Kumaran G, Zee YK, Murukesh N, Swindell R,

Saunders MP, Clamp AR, Valle JW, Wilson G, Jayson GC, Hasan J. J Clin Gastroenterol. 2014 May-Jun;48(5):430-4. doi: 10.1097/MCG.0b013e3182a8804c.

- Thrombosis in ovarian cancer: a case control study. Metcalf RL, Fry DJ, Swindell R, McGurk A, Clamp AR, Jayson GC, Hasan J. Br J Cancer. 2014 Mar 4;110(5):1118-24. doi: 10.1038/bjc.2014.3.
- Accessing cancer services in North West England: the Chinese population. Conway AM, Clamp AR, Hasan J, Goonetilleke D, Shore K, Wong LM, Wong J, Jayson G. Eur J Cancer Care (Engl). 2014 Jan 7. doi: 10.1111/ecc.12171.
- Ovarian cancer cell heparan sulfate 6-O-sulfotransferases regulate an angiogenic program induced by heparin-binding epidermal growth factor (EGF)-like growth factor/EGF receptor signaling. Cole CL, Rushton G, Jayson GC, Avizienyte E. J Biol Chem. 2014 Apr 11;289(15):10488-501. doi: 10.1074/jbc.M113.534263.
- Mixed-effects modeling of clinical DCE-MRI data: Application to colorectal liver metastases treated with bevacizumab. Ferl GZ, O'Connor JP, Parker GJ, Carano RA, Acharya SJ, Jayson GC, Port RE. J Magn Reson Imaging. 2014 Feb 6. doi: 10.1002/jmri.24514.
- The combination of circulating Ang1 and Tie2 levels predict progression free survival advantage in Bevacizumab-treated ovarian cancer patients. Backen A, Renehan A, Clamp A, Berzuini C, Zhou C, Oza AM, Bannoo S, Scherer SJ, Banks RE, Dive C, Jayson GC. Clin Cancer Res. 2014 Jun 19. pii: clincanres.3248.2013
- Jayson GC Angiogenesis as a target in Oncology. Together Chai Cancer Care Sept 2013
- Biomarkers and response to bevacizumab--response. Collinson F, Hutchinson M, Craven RA, Cairns DA, Alexandre Z, Wind TC, Gahir N, Messenger MP, Jackson S, Thompson D, Adusei C, Ledermann J, Hall G, Jayson GC, Selby PJ, Banks RE. Clin Cancer Res. 2014 Feb 15;20(4):1058
- Clamp AR, Jayson GC. Ovarian Cancer. Treatment of Cancer 6$^{th}$ Edition. Publ.: Hodder Arnold 2013
- Targeted anti-vascular therapies for ovarian cancer: current evidence. Hall M, Gourley C, McNeish I, Ledermann J, Gore M, Jayson G, Perren T, Rustin G, Kaye S. Br J Cancer. 2013 Feb 5;108(2):250-8.
- Angiogenesis as a target for the treatment of ovarian cancer. Shaw D, Clamp A, Jayson GC. Curr Opin Oncol. 2013 Sep;25(5):558-65
- Ovarian cancer. Jayson GC, Kohn EC, Kitchener HC, Ledermann JA. Lancet. 2014 Apr 17. pii: S0140-6736(13)62146-7. doi: 10.1016/S0140-6736(13)62146-7.

## 9. Innovation in clinical practice

The board will support the movement of suitable SACT treatment from the Christie to areas nearer the patients' homes. The target of 80% of such treatment being given within 20 minutes travel has nearly been met. The board will aim to move more suitable regimens out of the centre, while retaining a focus on cost-economics, particularly where expensive monoclonal antibodies are given.

Much of this strategy will be accomplished using the "Christie at…" model, where Christie governance procedures are extended to other units so that safety and satisfaction can be closely monitored. To support this approach the Board will aim to have non-medical prescribers at each site so that dose changes and delays can be made without inconvenience to the patients. Over

time, it will be important to bring all SACT treatment given under Manchester Cancer under unified governance arrangements with agreed regional protocols.

As cancer care advances the general model will be that all suitable treatments will be administered nearer to the patients' homes. This will allow the Christie to provide care for more complex and/or treatment resistant disease for patients the area and surrounding areas. In both the Christie and local units, the focus will be to support research as much as possible to maximise participation and thereby patient treatment.

## 10. The Pathway Board

### 10.1. Formation of the Board

The principle of Manchester Cancer Pathway Boards is that they should be professionally and institutionally representative, yet small and manageable in size. To help Pathway Clinical Directors form institutionally representative Boards the Manchester Cancer central team sought nominations from trusts for their representative(s) on 16 of the 20 Pathway Boards. Nominations were not sought for Children's, Sarcoma, Palliative Care and Early Diagnosis as alternative arrangements were necessary in these areas.

For each Pathway Board trusts were asked to provide up to three nominations from a range of professions from which the trust representative(s) could be chosen. The team asked that nominations included a brief statement of the individual's suitability for membership of the relevant Pathway Board.

Nominations were passed to Pathway Clinical Directors who took them into account when forming their Boards. Trusts were informed during this process that Directors would not be obliged to accept all trust nominations but that, if a Pathway Clinical Director wished to appoint a trust representative that had not been nominated by their organisation, and then this would be discussed with the Trust Cancer Clinical Lead.

The pathway director ensured that there was a wide range of stakeholders involved on the board.

### 10.2. Membership

The list of board members is below. At this point in time there is no patient or GP representative on the board. This remains a challenge and one that the pathway director is keen to overcome.

Identifying and supporting potential patient and GP members will be co-ordinated with Manchester Cancer.

| Trust | Nominee | Profession/ specialty |
|---|---|---|
| Bolton | Cheryl Downes | Chemotherapy CNS |
| | Dr Alam Nooreen | Oncologist |
| Christie | Dr Claire Mitchell | Acute Oncologist |
| | Mathew barker- Hewitt | Head of Information |
| | Dr Mike Dennis | |
| East Cheshire | Mrs Catherine Fensom | Oncology matron |
| | Dr Lisa Barraclough | Oncologist |
| Pennine | Dr Saifee Mullamitha | Oncologist |
| | Lindsey Newton | Macmillan Lead Nurse Chemotherapy |
| Salford | Ann Stout | Lead Nurse Chemotherapy |
| Stockport | Louise Abedin | Senior Oncology/ Palliative Care Pharmacist. Trust Chemotherapy Lead |
| Tameside | Dr Hussein Baden | Consultant Haematologist |
| UHSM | Dr Rafaelle Califano | Consulant Medical Oncologist |
| WWL | Leonora Anson | Oncology unit manager |
| | Dr Elena takeuchi | |
| NHS England | Robert Hallworth | Commissioner |
| Christie | Vicki Burns | |
| NIHR | Elaine Blowers | Lead research nurse |

### 10.3. Meetings

The board has been in existence since 28th April and has met twice in that period. However one of those meetings was with the previously outlined Christie Chemotherapy Group. Therefore the board has only met once as the constituted board. However, Professor Jayson as Chair is now a member of multiple regional medical, Christie and pharmacy committees to integrate these committee functions together.

The minutes of both meetings are in appendix 3.

## 11. Progress and challenges to date

The most important issue in improving cancer care in Manchester is the paucity of high quality data on a region-by-region basis. We will start to gather data on healthcare is being given now, in terms of safety, satisfaction and outcomes. There is an urgent need to know how the survival of common cancers varies around the city. Specifically we will start to gather data on metastatic

breast, colorectal and possibly also lung cancer. Thirty day survival statistics yield information on safety of drug administration. However, we need 2-year or median survival statistics for these tumours followed by immediate dissection of the regional pathways to understand the causes of variable regional survival.

As the volume of regionally delivered SACT increases, this will impact significantly on the oncologists providing that care and is likely to exceed their capacity to monitor on-going treatment. To address this issue the Board will make recommendations concerning the numbers of non-medical prescribers employed by each treating Trust or at each "Christie at…" site. This will optimise the use of SACT and therefore patient experience.

The UK funding environment for research has been impacted by the recent recession and the support for research nurses has been affected. The Board will develop research applications to support regional research and to assess the deliverability, patient satisfaction and cost-effectiveness of conducting phase 3 research in patients' local treatment centres.

Central to the devolution of treatment to the patients' local unit is the need for a unified, pan-Manchester IT system that allows medical notes and SACT prescription to occur. This will improve patient care, while allowing commissioners to see clearly the amount of SACT that is being administered throughout Manchester, thereby facilitating the commissioning process.

An additional issue is the need for Manchester Cancer to develop a unified governance and protocol-led system across the city. The ambition is that this will be applied across all treatment areas.

## 12. Vision and objectives

The Manchester Cancer Systemic Therapies Pathway Board exists to promote, enhance, improve and extend the provision of systemic anti-cancer therapies to patients with cancer across Greater Manchester and East Cheshire.

The Board is able to offer to policy makers, planners, service managers and practitioners valuable opportunities for the development, sharing and implementation of expert opinion, sound strategy and good practice.

The board will work to devolve suitable SACT closer to the patients and away from delivery of therapy at the Christie. This may have implications for recruitment into phase three clinical trials and the board's vision is that such recruitment will continue to grow as therapy is delivered away from the Christie site.

Correspondingly, the Christie will focus more on complex cancer management that will include, for instance, chemo-resistant disease. Thus phase I/II trials will be conducted at the Christie, where suitable patients are being treated, offering Manchester's patients access to the latest drug candidates for their cancers.

## Appendix 1 – Pathway Board Terms of Reference

**Manchester Cancer**

# Systemic therapies Cancer Pathway Board
Terms of Reference

These terms of reference were agreed on June 2014 by Professor Gordon Jayson, Pathway Clinical Director for Systemic therapies Cancer, and Mr David Shackley, Medical Director of Greater Manchester Cancer Services, on behalf of the Greater Manchester Cancer Services Provider Board. The terms of reference will be subject to future review.

## 1. The Pathway Board

1.1. The Systemic therapies Cancer Pathway Board is a cancer care specific board with responsibility to improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire (a catchment population of 3.2 million). This area is synonymous with the old Greater Manchester and Cheshire Cancer Network area.

1.2. The Pathway Board is led by a Pathway Clinical Director and is formed of a multidisciplinary team of clinicians and other staff from all of hospital trusts that are involved in the delivery of Systemic therapies cancer care in Greater Manchester. The Pathway Board also has membership and active participation from primary care and patients representatives.

1.3. The Systemic therapies Cancer Pathway Board reports into and is ultimately governed and held to account by the Greater Manchester Cancer Services Provider Board.

## 2. Greater Manchester Cancer Services Provider Board

2.1. The Greater Manchester Cancer Services Provider Board is responsible for the service and clinical delivery arm of Manchester Cancer, Greater Manchester's integrated cancer system. Manchester Cancer has two other arms: research and education (see appendix for the structure of Manchester Cancer).

2.2. The Provider Board is independently chaired and consists of the Chief Executive Officers of the ten acute hospital trusts in the Greater Manchester area:

- Bolton NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- East Cheshire NHS Trust
- Pennine Acute NHS Trust
- Salford Royal NHS Foundation Trust

- Stockport NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust
- The Christie NHS Foundation Trust
- University Hospital of South Manchester NHS Foundation Trust;
- Wrightington, Wigan and Leigh NHS Foundation Trust;

2.3. The Provider Board regularly invites representatives of commissioners, the Strategic Clinical Network, and Manchester Cancer to its meetings.

## 3. Purpose of the Pathway Board

3.1. The purpose of the Pathway Board is to improve cancer care for patients on the Greater Manchester Systemic therapies cancer pathway. Specifically, the Pathway Board aims to save more lives, put patients at the centre of care, and improve patient experience. The Board will represent the interests of local people with cancer, respecting their wider needs and concerns. It is the primary source of clinical opinion on this pathway for the Greater Manchester Cancer Services Provider Board and Greater Manchester's cancer commissioners.

3.2. The Pathway Board will gain a robust understanding of the key opportunities to improve outcomes and experience by gathering and reviewing intelligence about the Systemic therapies cancer pathway. It will ensure that objectives are set, with a supporting work programme that drives improvements in clinical care and patient experience.

3.3. The Pathway Board will also promote equality of access, choice and quality of care for all patients within Greater Manchester, irrespective of their individual circumstances. The Board will also work with cancer commissioners to provide expert opinion on the design of any commissioning pathways, metrics and specifications.

## 4. Role of the Pathway Board

The role of the Systemic therapies Cancer Pathway Board is to:

4.1. Represent the Greater Manchester Cancer Services professional and patient community for Systemic therapies cancer.

4.2. Identify specific opportunities for improving outcomes and patient experience and convert these into agreed objectives and a prioritised programme of work.

4.3. Gain approval from Greater Manchester's cancer commissioners and the Greater Manchester Cancer Services Provider Board for the programme of work and provide regular reporting on progress.

4.4. Design and implement new services for patients where these progress the objectives of commissioners and Greater Manchester Cancer Services, can be resourced, and have been shown to provide improvements in outcomes that matter to patients.

4.5. Ensure that diagnosis and treatment guidelines are agreed and followed by all teams in provider trusts, and are annually reviewed.

4.6. Ensure that all providers working within the pathway collect the pathway dataset measures to a high standard of data quality and that this data is shared transparently amongst the Pathway Board and beyond.

4.7. Promote and develop research and innovation in the pathway, and have agreed objectives in this area.

4.8. Monitor performance and improvements in outcomes and patient experience via a pathway scorecard, understanding variation to identify areas for action.

4.9. Escalate any clinical concerns through provider trusts.

4.10. Highlight any key issues that cannot be resolved within the Pathway Board itself to the Medical Director of Greater Manchester Cancer Services for assistance.

4.11. Ensure that decisions, work programmes, and scorecards involve clearly demonstrable patient participation.

4.12. Share best practices with other Pathway Boards within Greater Manchester Cancer Services.

4.13. Contribute to cross-cutting initiatives (e.g. work streams in living with and beyond cancer and early diagnosis).

4.14. Discuss opportunities for improved education and training related to the pathway and implement new educational initiatives.

4.15. Develop an annual report of outcomes and patient experience, including an overview of progress, difficulties, peer review data and all relevant key documentation. This report will be published in July of each year and will be the key document for circulation to the Provider Board. A template for this report is available so that all Pathway Boards complete the report in a similar manner.

## 5. Membership principles

5.1. All member organisations of Greater Manchester Cancer Services will have at least one representative on the Pathway Board unless they do not wish to be represented.

5.2. Provider trusts not part of Greater Manchester Cancer Services can be represented on the Pathway Board if they have links to the Greater Manchester SYSTEMIC THERAPIES cancer pathway.

5.3. All specialties and professions involved in the delivery of the pathway will be represented.

5.4. The Board will have at least one patient or carer representative within its membership

5.5. One professional member of the Pathway Board will act as a Patient Advocate, offering support to the patient and carer representative(s).

5.6. The Board will have named leads for:

- Early diagnosis
- Pathology
- Radiology
- Surgery
- Oncology
- Specialist nursing
- Living with and beyond cancer ('survivorship')
- Research
- Data collection (clinical outcomes/experience and research input).

5.7. It is possible for an individual to hold more than one of these posts. The Pathway Clinical Director is responsible for their fair appointment and holding them to account.

5.8. These named leads will link with wider Greater Manchester Cancer Services Boards for these areas where they exist.

5.9. All members will be expected to attend regular meetings of the Pathway Board to ensure consistency of discussions and decision-making (meeting dates for the whole year will be set annually to allow members to make arrangements for their attendance).

5.10. A register of attendance will be kept: members should aim to attend at least 5 of the 6 meetings annually and an individual's membership of the Pathway Board will be reviewed in the event of frequent non-attendance.

5.11. Each member will have a named deputy who will attend on the rare occasions that the member of the Board cannot.

## 6. Frequency of meetings

6.1. The Systemic therapies Cancer Pathway Board will meet every two months.

## 7. Quorum

7.1. Quorum will be the Pathway Clinical Director plus five members of the Pathway Board or their named deputies.

## 8. Communication and engagement

8.1. Accurate representative minutes will be taken at all meetings and these will be circulated and then validated at the next meeting of the Board.

8.2. All minutes, circulated papers and associated data outputs will be archived and stored by the Pathway Clinical Director and relevant Pathway Manager.

8.3. The Pathway Board will design, organise and host at least one open meeting per year for the wider clinical community and local people. This meeting or meetings will include:

- An annual engagement event to account for its progress against its work programme objectives and to obtain input and feedback from the local professional community

- An annual educational event for wider pathway professionals and interested others to allow new developments and learning to be disseminated across the system

8.4. Representatives from all sections of the Greater Manchester Cancer Services professional body will be invited to these events, as well as patient and public representatives and voluntary sector partners.

8.5. An annual report will be created and circulated to the Medical Director of the Greater Manchester Cancer Services Provider Board by 31st July of each calendar year.

8.6. The agendas, minutes and work programmes of the Pathway Board, as well as copies of papers from educational and engagement events, will be made available to all in an open and transparent manner through the Greater Manchester Cancer Services website once this has been developed.

## 9. Administrative support

9.1. Administrative support will be provided by the relevant Pathway Manager with the support of the Greater Manchester Cancer Services core team. Over the course of a year, an average of one day per week administrative support will be provided.

## 13. Appendix 2 – Pathway Board meeting attendance

| NAME | ROLE | TRUST | 28th April 14 | 23rd June 14 |
|---|---|---|---|---|
| Cheryl Downes | Chemotherapy CNS | Bolton | Apologies | Aplologies |
| Dr Alam Nooreen | Oncologist | | | Aplologies |
| Dr Claire Mitchell | Acute Oncologist | Christie | | Aplologies |
| Mathew barker- Hewitt | Head of Information | | Attend | Attended |
| Dr Mike Dennis | Consultant | | Sent representative | Aplologies |
| Mrs Catherine Fensom | Oncology matron | East Cheshire | Attend | Attended |
| Dr Lisa Barraclough | Oncologist | | Attend | Apologies |
| Dr Saifee Mullamitha | Oncologist | Pennine | | Dr V Misra |
| Lindsey Newton | Macmillan Lead Nurse Chemotherapy | | Attend | Attended |
| Louise Abedin | Senior Oncology/ Palliative Care Pharmacist. Trust Chemotherapy Lead | Stockport | | Attended |
| Dr Hussein Baden | Consultant Haematologist | Tameside | | Apologies |
| Dr Rafaelle Califano | Consulant Medical Oncologist | UHSM | | Attended |
| Leonora Anson | Oncology unit manager | WWL | Apologies | Apologies |
| Dr Elena Takeuchi | Consultant Haematologist | | | Attended |
| Robert Hallworth | Commissioner | NHS England | Attend | Attended |
| Vicki Burns | Chemotherapy project lead | Christie | Attend | Attended |
| Elaine Blowers | Lead research nurse | NIHR | Attend | Attended |
| Ursula McMahon | | WWL | Attend | Apologies |
| Sarah Khan | | Bolton | | Apologies |
| Michelle Rowe | Pharmacy | Christie | Attend | Aplologies |
| Steve Wardell | Pharmacy | Christie | Attend | Apologies |
| Rob Duncombe | Pharmacy | Christie | Attend | Apologies |
| Mathew Barker-Hewitt | Information | Christie | Attend | Attended |
| Scott Watson | Informatics | Christie | Attend | Attended |
| | | | | |
| | | | | |

## 14. Appendix 3 – Pathway Board minutes to 31st July 2014

**SYSTEMIC THERAPIES PATHWAY BOARD MEETING**
**(Held in conjunction with the Christie chemotherapy delivery group)**

**MINUTES**

**DATE: 28/04/2014**

**Member's attendance**

| | | | |
|---|---|---|---|
| **Prof Jayson (Chair)** | **Christie** | **Dilly Goonetilleke** | **UoM** |
| **Claire Mitchell** | **Christie** | **Dr Wardley** | **Christie** |
| **Louise Adebin** | **Stockport** | **Bernie Delahoy** | **Christie** |
| **Sarah Khan** | **Bolton** | **Dr Mullimatha** | **Christie** |
| **Dr Califano** | **UHSM** | **Stephen Wardell** | **Christie** |
| **Dr Hubner** | **Christie** | **Michelle Rowe** | **Christie** |
| **Catherine Fensom** | **East Cheshire** | **Rob Duncombe** | **Christie** |
| **Lindsey Newton** | **Pennine** | **Dr McGurk** | **Christie** |
| **Vicki Burns** | **Christie** | **Dr Cavet** | **Christie** |
| **Jackie Wrench** | **Christie** | **Susan Blair** | **Christie** |
| **Elaine Blowers** | **Christie** | **Matt Barker Hewitt** | **Christie** |
| **Anne Armstrong** | **Christie** | **Ursula McMahon** | **WWL** |
| **Dr Harris** | **Christie** | **Dr Barraclough** | **Christie** |

**Apologies**

| | | | |
|---|---|---|---|
| **Leonora Anson** | **WWL** | **Cheryl Downes** | **Bolton** |
| **Dr Takeuchi** | **WWL** | | |

**In attendance**

| | |
|---|---|
| **James Leighton** | **Manchester cancer** |
| **Robert Hallworth** | **NHS England** |

- **Introductions and apologies**

Prof Jayson (GJ) welcomed all to the meeting and noted the apologies received.

- **Introduction to Manchester cancer**

GJ outlined the purpose of the pathway board and clarified that the role of members is in reviewing the whole pathway as a stakeholder in improving the outcomes for patients. He stressed that the priority would be to create and maintain an efficient and effective pathway and deliver more systemic therapies closer to the patient.

GJ explained that as the agenda of the pathway board and the Christie SACT delivery group were very similar that it would be useful to have a joint meeting in the first instance and at regular intervals thereafter.

Those attending the meeting then provided introductions.

- **Board membership**

James Leighton (JL) explained that there would be a patient representative on the board; however their participation would occur after an engagement event to be held in conjunction with Macmillan cancer. *(Since the board meeting the engagement event is now confirmed to take place on 23rd June)*

- **Terms of reference**

This was not discussed as it was a joint meeting with the Christie Chemotherapy delivery group. The terms of reference will be discussed at the next meeting of the board.
**Action – to be put onto agenda on next pathway board meeting JL**

- **Discussion of board objectives**

GJ then outlined what are the outline objectives for the work of the board which at this stage is mainly to deliver 80% of clinically appropriate SACT closer to the patient's home whilst maintaining and developing phase 3 research capacities.

GJ then led a discussion with the board on the issues that may compromise a successful outcome to these objectives. This involved a review of current capacity on all sites across the greater Manchester and Cheshire footprint.

During this discussion a number of risk factors were discussed, such as –

- Where and how Haematological –oncology would be supported in this process
- Acute oncology capacity and the impact on AO of devolving SACTs
- IT infrastructure to support devolved SACT
- Wastage of drugs on site

Louise Adebin (LA) a Macmillan pharmacist then gave an outline of her role and how she has delivered a reduction in drugs wastage in Stepping Hill by the introduction of the Therapy pharmacist role.

LA is based within the chemotherapy unit at SHH and delivers 2 clinics a week for oral chemotherapy patients following the patients through the course of their treatments. She also prescribes the treatments after the initial prescription as well as all supportive medicines.

She explained how other process changes were introduced to help reduce the amount of drug wastage on the unit.

The board agreed that at each of the sites the role of a prescribing pharmacist / nurse should be developed and deployed, with a support infrastructure integrated at the same time.

Rob Hallworth (RH), NHS England, then outlined the commissioning intentions for SACT over the next 5 years.

There was then a round table discussion on how to preserve phase three clinical trials as more SACT is devolved away from the Christie. GJ outlined a proposed new role of Chemotherapy research nurses that could be developed to effectively run clinical trials at remote sites.

GJ informed the board that he would, in collaboration with the Christie, put a bid into the NIHR for five research nurses over a five year period. If successful they would be deployed into the "Christie at" sites.

This was followed by a discussion on IT infrastructure support for e-prescribing. Currently either Medway or Ascribe systems were now available. However there remains a lack of clinical support that results in the systems being underused. Also, the Christie is changing its IT systems such that dissemination of a unified IT process across the city was not feasible at this point.

The board felt that there was a need to standardise the system used for SACT prescribing across GM and Cheshire.

GJ then led a discussion on the potential need for a centre for complex care, to manage the care for those patients coming from out of the area, second opinions and patients with complex care needs.

The discussion came to a conclusion and the outline work plan agreed was –

Centre for complex care
Therapy pharmacist role across GM
Develop the Chemotherapy research nurse
Standardise infrastructure support for e-prescribing

- **Board roles**

To be agreed at pathway board meeting on 23rd June

- **Educational event**

Deferred until next pathway board meeting

- **Any other business**

There was no other business raised.

- **Date & Venues for Future Meetings**

The next meeting of the board will be on **Monday 23rd June** 15.00hrs and will be in the Wolfson Molecular Imaging Centre, Ground Floor meeting room.

This is next door to Christie Hospital via Christie Palatine Road access.

# SYSTEMIC THERAPIES PATHWAY BOARD MEETING
# MINUTES
# DATE: 23/06/2014

**Member's attendance**

| | | | |
|---|---|---|---|
| **Prof Jayson (Chair)** | **Christie** | **Dilly Goonetilleke** | **UoM** |
| **Louise Adebin** | **Stockport** | **Catherine Fensom** | **East Cheshire** |
| **Elaine Blowers** | **Christie** | **Matt Barker Hewitt** | **Christie** |
| **Dr Califano** | **UHSM** | **Lindsey Newton** | **Pennine** |
| **Vicki Burns** | **Christie** | **Dr Takeuchi** | **WWL** |
| **Robert Hallworth** | **NHS England** | **Dr Misra** | **Christie** |
| **Scott Watson** | **Informatics** | **Ann Stout** | **Salford** |

**Apologies**

| | | | |
|---|---|---|---|
| **Leonora Anson** | **WWL** | **Cheryl Downes** | **Bolton** |
| **Dr Barraclough** | **Christie** | **Dr Mitchell** | **Christie** |
| **Dr Dennis** | **Christie** | | |

**In attendance**

| | |
|---|---|
| **James Leighton** | **Manchester cancer** |

- **Introductions and apologies**

Prof Jayson (GJ) welcomed all to the meeting and noted the apologies received.

- **Minutes of the last meeting**

The minutes of the last meeting were accepted as a true record. The matters arising were –

  - NIHR bid for research nurses to support phase 3 research. Elaine Blowers(EB) informed the board that she was intending to visit units in Birmingham and Cambridge that currently have such support in place. She is also linking up with education department to support chemotherapy nurses about phase 3 trial and setting up service level agreements with all the provider units to support the phase 3 trials. There was then a discussion on how feasible it would be to set a target figure for trial recruitment. Prof Jayson (GJ) and EB agreed to have further discussions away from the meeting to better understand and consider the workforce capacity for this.
    - **Action** GJ and EB to meet to scope the potential for setting a target at organisational level for phase 3 recruitment.
  - Chemotherapy prescribing pharmacists Louise Adebin (LA) gave an update on actions since the last meeting. There followed a discussion on how the pharmacists may be mentored during training. The board agreed that the current prescribing pharmacist workforce needs to be scoped to develop a position statement outlining on what staff would be required. This should be done in conjunction with the chief pharmacist in each unit with the aim of there being a minimum of two non-medical prescriber per unit.

- **Board membership**
- **Terms of reference**

James Leighton (JL) outlined the standard terms of reference and their purpose. The board felt that the identified board roles were not suitable for this group. The board were asked to reflect on any changes they feel are necessary to the ToR and bring back to the next meeting. Until then then these ToR will apply.
**Action** the board to review at their next meeting

- **Discussion of board objectives**

GJ led a discussion on what data and clinical outcomes should be gathered to inform the work of the board. The suggested measures were –

30 day mortality
Acute oncology cover
The volume of non-Christie delivered haematology
Errors/clinical incidents
Adverse drug reactions
Drug wastage
Waiting time
Patient satisfaction
Phase 3 clinical trial recruitment
Socio-economic pattern of mortality/survival

The board then had a discussion on what resources would be available to deliver this level of data gathering. Matt Barker Hewitt (MBH) outlined to the board the challenges in providing this. However GJ suggested that this could be mitigated by just looking at the top 3 disease types. There was no resolution on this, and the board asked that this is fed back to Manchester Cancer for discussion.
**Action** JL to feed back to Manchester Cancer

- **Educational event**

GJ felt that this was better delivered as part of disease orientated talks rather than as stand-alone systemic therapies education events. The board concurred with this view. GJ however suggested that oncological emergencies may perhaps be a suitable topic of a primary care audience.

- **Any other business**

GJ informed the board about his site visit to Wigan cancer unit and how impressed he was by the unit and the positive responses he got from the patients.

He went onto to discuss that in the sites Haematology is managed as a separate unit and not as a cohesive unit. This raised some issues because of the fact the 40-45% of activity is delivered by haematologists. GJ suggested that he meet with the pathway director of the haematology board to discuss how more integration in delivery could occur.

GJ also informed the board that he would also be working on the Christie 5-year SACT strategy and that this would complement the work of the pathway board.

Robert Hallworth informed the group that he had met the CEO of Trafford CCG, in her role as lead cancer commissioner and GJ suggested that it might be appropriate for him to join in a meeting on delivery of chemotherapy closer to home.
**Action** RH to arrange this meeting

Scott Watson (SW) gave the board an update on the deployment of informatics technology and electronic prescribing. GJ raised concerns that without electronic records it is possible for clinicians to remain uniformed about adverse reactions.

- Annual report

JL outlined the annual report and the process that is involved.

- **Date & Venues for Future Meetings**

**September 15th 15.00 – 17.00**
Joint meeting with Christie Chemotherapy delivery group
Trust admin meeting room 6

# 15. Appendix 4 – Pathway Board Annual Plan 2014/15

**Pathway Board Annual Plan 2014-15**

| | |
|---|---|
| **Pathway Clinical Director:** | Professor Gordon Jayson |
| **Pathway Board Members:** | |
| **Pathway Manager:** | James Leighton |
| **Date agreed by Pathway Board:** | To be ratified at next pathway board |
| **Date agreed by Medical Director:** | To be confirmed |
| **Review date:** | |

**Summary of objectives**

| No | Objective | Alignment with Provider Board objectives |
|---|---|---|
| 1 | **Improved data collection to generate outcome data** | **Improve survival rates** |
| 2 | **Increase the number of non-medical prescribers within SACT units** | **Patient experience** |
| 3 | **Development of research nurses within SACT delivery site** | **Recruitment to research trials** |
| 4 | | |
| 5 | | |

## Objective 1: Improved data collection to generate outcome data

| | | |
|---|---|---|
| **Objective:** | To optimise data collection to allow the generation of meaningful outcome measures on survival for Lung, Breast and colo-rectal | |
| **Rationale:** | The Board wishes to be able to reliably generate meaningful annual outcome data, to facilitate national and international comparison, and year on year comparison of our own outcomes.<br>This will ensure that the patient care delivered compares favourably with other centres and identify areas where care might be improved. | |
| **By (date):** | 31/3/15 | |
| **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 e.g. cancer lead clinicians, MDT co-ordinators, data managers, doctors, clinical nurse specialists.<br>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 in generating and analysing this data. | |

| **Work programme - - To be agreed by the board** | | |
|---|---|---|
| **Action** | **Resp.** | **By (date)** |
| Agree the outcome measures | Board | |
| Devise a strategy for collection of data | Board | Sept 14 |
| Identify gaps in data collection | GJ /JL | Dec 14 |
| Implement remedies to ensure data is collected | GJ /JL | |

## Objective 2: Increase the number of non-medical prescribers within SACT units

| | |
|---|---|
| **Objective:** | To increase the number of non-medical prescribers within SACT delivery units. |
| **Rationale:** | Delivery of SACTs is often compromised by the level of medical support, which can result in delays, wastage and reduced capability to amend and respond to prescribed treatments |
| **By (date):** | 31 March 2015 |
| **Board measure(s):** | Increased number of non-medical prescribers |
| **Risks to success:** | Time and other commitments of involved personnel.<br><br>Mitigation: Aim for an efficient, unified, sustainable approach |
| **Support required:** | Recognition and protection of the vital role of non-medical prescribers and the effort and commitment in undertaking this role.<br>Integrating the ambition of the pathway board with the participating Trusts ability to deliver this role. |

.

| **Work programme** | | |
|---|---|---|
| **Action** | **Resp.** | **By (date)** |
| Undertake a scoping exercise of current NMP workforce | LA | Sept 14 |
| Identify numbers of staff required | LA | Sept 14 |
| Begin training of staff` | Trusts | March 15 |
| | | |

## Objective 3: Development of research nurses within SACT delivery sites

| | |
|---|---|
| **Objective:** | To attract research funding to allow the development of research nurses within each SACT delivery site. |
| **Rationale:** | There is a significant risk that as more SACT is delivered away from the Christie that the numbers of patients recruited into phase 3 clinical trials could fall. To address this it is proposed to put a nurse trained in research into each site |
| **By (date):** | To have confirmation of funding by December b2014 |
| **Board measure(s):** | Recruitment of the required number of research nurses |
| **Risks to success:** | If the application for funding is unsuccessful. This can only be mitigated by ensuring a successful application |
| **Support required:** | |

**Work programme**

| **Action** | **Resp.** | **By (date)** |
|---|---|---|
| Funding application submitted | GJ | May 2014 |
| Work programme to be put in place once outcome of application has been agreed. | | |
| | | |
| | | |