Manchester Cancer

Urology Cancer Pathway Board

Annual Report 2014/15

Pathway Clinical Director: Mr Satish Maddineni
Pathway Manager: James Leighton

Version 1.2

Executive summary

The Urology pathway board is now a well-established and highly functioning board. It has representation from all stakeholder trusts with in-patient urology services and key stakeholder uro-oncology service groups. Since the 2013/14 annual report the board has an identified patient representation.

Over the last 12 months the board has been responsive, positive, constructive and engaged with the Specialist Commissioners in the Uro-oncology procurement process. The board will look to build on this over the next 12 months.

However the anticipated reconfiguration and the procurement process itself were a significant challenge to the board. Whilst the board did not allow 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 annulled 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 urological oncology across the conurbation. This year it has successfully –

- Developed and implemented diagnostic renal cancer guidelines
- Developed and implemented a protocol for the active surveillance of patients diagnosed with low to intermediate risk prostate cancer
- Successfully obtained competitive funding of £25,000 to pilot a multi-disciplinary out-patient clinic to support patients living with and beyond their disease
- Successfully obtained competitive funding of £17,000 to pilot the cardiovascular and bone density sequelae of hormonal manipulation in advanced prostate cancer.
- Undertaken and reported an audit into cystoscopy post radical radiotherapy

The board are proud of these key achievements which were undertaken during a period of uncertainty for all stakeholder organisations.

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.

The board feel that the work undertaken so far in supporting 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 limited.

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

The board will also undertake a patient experience survey in the absence of the national cancer patient experience survey. This will be done in collaboration with the relevant stakeholder Trusts and, if necessary, established patient support groups.

The board intends to continue to support the agenda of the early detection, prevention and awareness cross cutting group.

In summary, in the coming year the board has identified the following key objectives:

- Develop service standards the help to define the service
- Widen stakeholder engagement by holding an open meeting
- Agree the key clinical outcomes and outputs that will begin to define the service
- Standardise the prostate follow up process across Greater Manchester and East Cheshire
- 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 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.

1. Introduction – the Pathway Board and its vision

This is the annual report of the Manchester Cancer Urology 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 it 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 the reconfiguration of the service across Greater Manchester, Cheshire and High Peak. This year the board has supported the commissioners through the previous annulled procurement and will continue do so over the next twelve months.

Over this period 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 continue its work across the whole pathway and put in place actions where patient outcomes, survival rates and experience can be improved and enhanced.

1.2. Membership

The current membership of the board is as below –

Nominee	Profession/ specialty
Satish Maddineni	**CHAIR**
Dr George Yeung	Consultant Radiologist
Prof Noel Clarke	Consultant Urologist
Mr Dan Burke	Consultant Urologist
Mr Jeremy Oates	Consultant Urologist
Mr John Calleary	Consultant Urologist
Mr Kieran O'Flynn	Consultant Urologist
Mr Stephen Bromage	Consultant Urologist
Mr J Husain	Consultant Urologist
Miss Hazel Warburton	Consultant Urologist
Jane Booker	Clinical Nurse Specialist
Ted Chatt	Patient Representative
Maryna Lewinski	Consultant Radiologist
Mike Scott	Consultant Pathologist
Helen Johnson	Clinical Nurse Specialist "Living with and beyond cancer representative"
Tony Elliot	Consultant Oncologist
Steve Elliot	GP
Cath Briggs	GP
Anna Tran	Consultant Oncologist
Fiona Thistlethwiate	Consultant Oncologist

1.3. Meetings

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

10th June 2014
http://manchestercancer.org/wp-content/uploads/2014/09/Urology-Pathway-Board-Meeting-Minutes1.pdf

24th July 2014
http://manchestercancer.org/wp-content/uploads/2014/09/Urology-Pathway-Board-Meeting-Minutes2.pdf

5th September 2014
http://manchestercancer.org/wp-content/uploads/2014/09/Urology-Pathway-Board-Meeting-Minutes3.pdf

11th November 2014
http://manchestercancer.org/wp-content/uploads/2014/09/Urology-Pathway-Board-Meeting-Minutes4.pdf

13th January 2015
http://manchestercancer.org/wp-content/uploads/2014/09/Urology-Pathway-Board-Meeting-Minutes5.pdf

20th May 2105

Holding board meetings within working hours will always be a challenge for clinical staff. However overall attendance has been satisfactory 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.

At this point in time the board has no plans for educational events as it is waiting for the cancer education strategy to be developed by Manchester Cancer. Once this strategy has been agreed the board will support and contribute to all urological cancer education as required.

The board is also intending to hold an open board meeting in the autumn of 2015, which will be for the wider urological cancer workforce, and other stakeholders, to become involved in and interact with the work of the board.

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, scrutiny of the data collected to enable the sustainable generation of outcome measures.	Objective no 1	Await the completion of the CWP pilots in lung		
			If the pilot is successful the board will co-ordinate the urology MDTs to be able to deploy CWP		
2	To review the MR scanning protocol for diagnosed prostate patients across the Manchester cancer area.	Objective no 4			
3	To develop and agree a policy for the active surveillance for men diagnosed with raised PSA but who are non-symptomatic.	Objective no 1			
4	Confirming the key clinical outcomes to be measured for bladder, renal and prostate cancer	Objective no 1	The board are awaiting the outcomes from the National reference group		

3. Improving outcomes, with a focus on survival

3.1. Information

There are 5 urological cancer types, Bladder, prostate, renal, testes and penile.

Bladder cancer is the seventh most common cancer in the UK (2011), accounting for 3% of all new cases. In males, it is the fourth most common cancer (4% of male total), whilst it is the 13th most common cancer in females (2% of female total).[1-4]

In 2011, there were 10,399 new cases of bladder cancer in the UK 7,452 (72%) in men and 2,947 (28%) in women, giving a male: female ratio of around 2.5:1. The crude incidence rate shows that there are 24 new bladder cancer cases for every 100,000 males in the UK, and 9 for every 100,000 females.

Bladder cancer is the 7th most common cause of cancer death in the UK (2011) accounting for 3% of all deaths from cancer. In men it is the 6th most common cause of cancer death (2011), accounting for 4% of all male deaths from cancer. Amongst women in the UK, bladder cancer is the 12th most common cause of cancer death (2011), accounting for 2% of all female cancer deaths.

In 2011, there were 5,081 deaths from bladder cancer in the UK 3,408 (67%) in men and 1,673 (33%) in women, giving a male: female ratio of more than 2:1. The crude mortality rate shows that there were 11 cancer deaths for every 100,000 males in the UK, and 5 for every 100,000 females.

Age-Standardised One, Five and Ten Year Relative Survival Rates, Adults Aged 15-99, England 2005-2009, England and Wales 2007

	Relative Survival (%)		
	1 Year	5 Year	10 Year
Sex	2005-2009	2005-2009	2007*
Male	78.4	58.2	51.5
Female	68.2	50.2	42.4

*The ten-year survival rates have been predicted for patients diagnosed in 2007 (using the hybrid approach).
Note: Survival for one and five years is for England only and for ten years is for England and Wales

Prepared by Cancer Research UK

Prostate cancer is the most common cancer in men in the UK (2011), accounting for 25% of all new cases of cancer in males.[1-4] In 1990, both lung and bowel cancers were more common in males than prostate cancer, but by 1998 prostate cancer was the most common cancer in UK males.

In 2011, there were 41,736 new cases of prostate cancer in males in the UK. The crude incidence rate shows that there are 134 new prostate cancer cases for every 100,000 males in the UK.

Prostate cancer is the 4th most common cause of cancer death in the UK (2011), accounting for around 7% of all cancer deaths. It is the second most common cause of

cancer death among men (2011) in the UK, accounting for 13% of all male deaths from cancer.

In 2011, there were 10,793 deaths from prostate cancer in the UK. The crude mortality rate shows that there are 35 prostate cancer deaths for every 100,000 males in the UK.

Age-Standardised One, Five and Ten Year Relative Survival Rates, Adults Aged 15-99, England 2005-2009, England and Wales 2007

	Relative Survival (%)		
	1 Year	5 Year	10 Year
Sex	2005-2009	2005-2009	2007*
Male	93.5	81.4	68.5

*The ten-year survival rates have been predicted for patients diagnosed in 2007 (using the hybrid approach).
Note: Survival for one and five years is for England only and for ten years is for England and Wales

Prepared by Cancer Research UK

Renal cancer is the 8th most common cancer in the UK (2011), accounting for around 3% of all new cases. In males, it is the 7th most common cancer (4% of the male total), whilst it is 10th in females (2%).

In 2011, there were 10,144 new cases of renal cancer in the UK, 6,257 (62%) in men and 3,887 (38%) in women, giving a male: female ratio of around 1.6:1. The crude incidence rate shows that there are 20 new renal cancer cases for every 100,000 males in the UK, and 12 for every 100,000 females.

Renal cancer is the 12th most common cause of cancer death in the UK (2011), accounting for 3% of all deaths from cancer. It is the 9th most common cause of cancer death among men in the UK (2011), accounting for 3% of all male deaths from cancer. Among women in the UK, Renal cancer is the 14th most common cause of cancer death (2011), accounting for 2% of all female cancer deaths.

In 2011, there were 4,189 deaths from renal cancer in the UK (**Table 2.1**): 2,572 (61%) in men and 1,617 (39%) in women, giving a male: female ratio of around 16:10. The crude mortality rate shows that there are 8 cancer deaths for every 100,000 males in the UK, and 5 for every 100,000 females.

Age-Standardised One, Five and Ten Year Relative Survival Rates, Adults Aged 15-99, England 2005-2009, England and Wales 2007

	Relative Survival (%)		
	1 Year	5 Year	10 Year
Sex	2005-2009	2005-2009	2007*
Male	71.5	53.3	43
Female	71.4	54.8	44.3

*The ten-year survival rates have been predicted for patients diagnosed in 2007 (using the hybrid approach).
Note: Survival for one and five years is for England only and for ten years is for England and Wales

Prepared by Cancer Research UK

2,207 men in the UK were diagnosed with testicular cancer in 2011. There were 68 deaths from testicular cancer in the UK in 2011 and 97.2% of adult testicular cancer patients in England survived their cancer for five years or more in 2005-2009.

Penile cancer is very rare and there are around 500 cases in the UK every year.

The Christie clinical outcome unit has begun to interrogate and report on clinical outcomes data extracted from the clinical web portal. The first of these reports is on prostate cancer and can be found at -
http://www.christie.nhs.uk/media/835757/ClinicalOutcomesUnitReport_Prostate_April2015.pdf

3.2. Progress

The board will this year start the process of auditing outcome data for patients with urological cancer. It will in the first instance agree what outcome measures it wishes to monitor. Ideally this will also include data from the Christie for those patients on a non-surgical element of the pathway.

3.3. Challenges

The biggest challenge to reporting on the outcomes of treatment, such as 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.

Improving patient experience

3.4. Information

The 2014 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 2014 National Cancer Patient Experience Survey for Urology cancer patients can be found in the embedded document below.

survey results_urology.xlsx

For the 8 questions identified as key indicators the response for Urology 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 - Urology	81%	68%	72%	69%	64%	88%	83%	89%
Manchester Cancer - Urology	81%	70%	74%	73%	68%	89%	84%	89%

3.5. Progress

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

3.6. Challenges

The 4 SMDTs are active in clinical research at a local level and 2 regularly present and publish research. Some studies require very challenging streamlining of patient pathways to meet tight study timelines, and all the MDT function cohesively to deliver this.

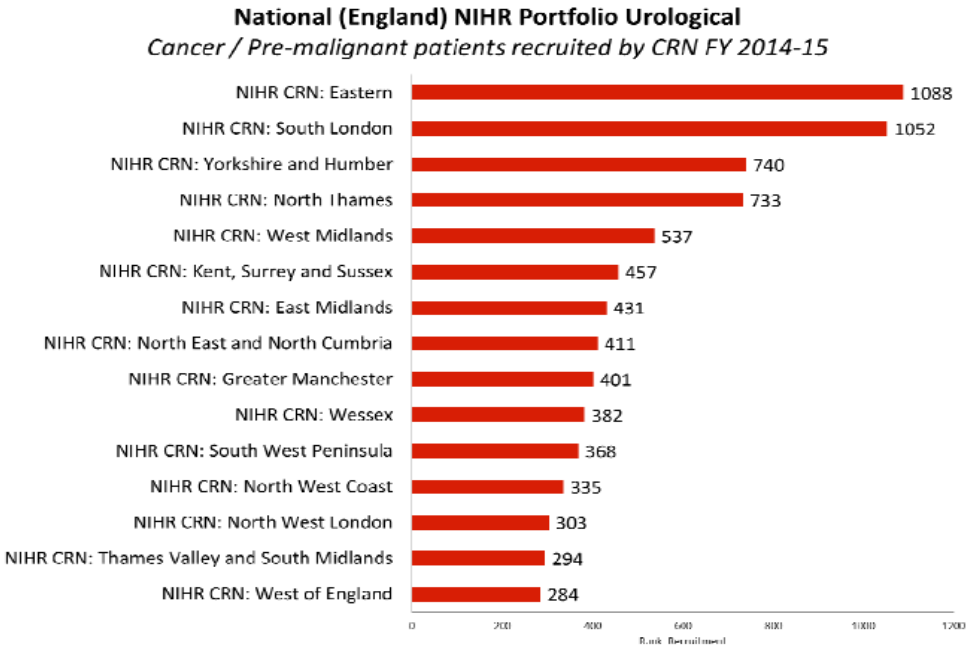
Recruitment relies not just on offering and conducting trials, but on having trials to offer. The MDTs and the board will engage with Sponsors to ensure that all possible industry-sponsored and NCRN portfolio studies are available to the patients of Greater Manchester, Cheshire and High Peak, and that 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.

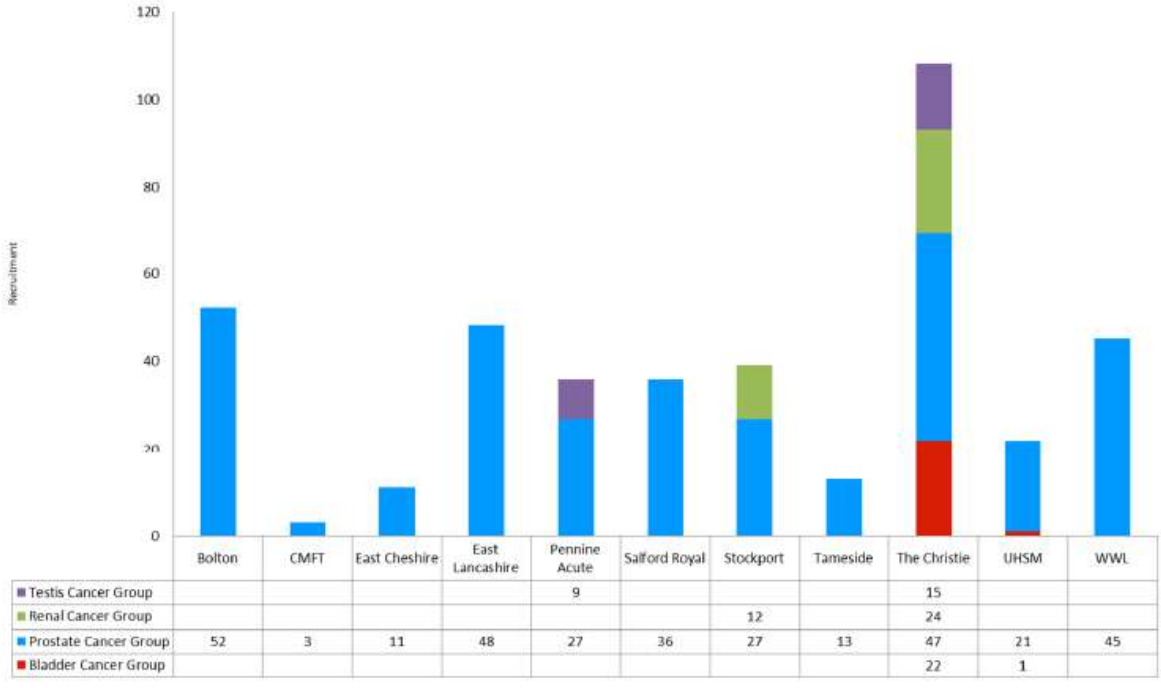
Increasing research and innovative practice

3.7. Information

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



The recruitment by Trust over this period is below –



	Bolton	CMFT	East Cheshire	East Lancashire	Pennine Acute	Salford Royal	Stockport	Tameside	The Christie	UHSM	WWL
Testis Cancer Group					9				15		
Renal Cancer Group							12		24		
Prostate Cancer Group	52	3	11	48	27	36	27	13	47	21	45
Bladder Cancer Group									22	1	

3.8. Progress

This is a standing item on all board agendas and the research lead, Dr Tony Elliot, updates the board on progress and any issues that are raised by the report.

3.9. Challenges

The main reasons for the recruitment levels were that there are a large number of centres contributing to limited/sole site studies that the NIHR are not part of the NIHR portfolio. (E.g. Eastern VoxTox observational study) Trusts could also improve recruitment to some all-site observational studies (notably testicular cancer) and this will be progressed as part of the work of the board.

Also some centres were generally poor recruiters but staffing reasons underpinned most of these issues (and these are in the process of resolution). The board feel that the key to successful clinical research recruitment was that there was a co-ordinated front to the participation and will continue to work to achieve that end.

4. Delivering compliant and high quality services

4.1. Information

CCGs and General Practitioners refer all new patients with cancer or suspected cancer to their local urological team under the terms of reference of the 2 week rule. The local team provide care for their own catchment, referring patients on to the specialist urological cancer teams for specialist care and treatment and referring patients to Oncologists at the Christie Hospital for radiotherapy, and for chemotherapy.

There are four specialist urological multi-disciplinary teams (SMDT) that provide specialist care for their referring catchment. Each of the specialist teams will also provide local care to the catchment for their localities. Specialist surgery and immediate post-operative care will be provided by the specialist teams in the named hospitals.

Members of the UHSM and Salford teams also work in the supra-network team at The Christie. Complex Urological / pelvic cancer, robotic assisted laparoscopic prostatectomy, penile cancer and post treatment salvage surgery for testis cancer are currently managed there.

The SMDTs are -

Host Trust	Urology SMDT Lead Clinician	Referring local MDTs	Catchment Population *
CMFT (operating site CMFT)	Mr Neeraj Sharma	Pennine	856,830
		CMFT	215,295
		Trafford	236,996
		Total	**1,309,121**
Salford (operating siteSalford)	Mr Satish Maddineni	Wrightington, Wigan & Leigh	321,084
		Salford	253,112
		Bolton	297,958
		Total	**872,154**
Stockport (operating site Stockport)	Mr Richard Brough	High Peak (out of Network)	50,000
		Stockport	301,096
		East Cheshire	204,353
		Mid-Cheshire	278,945
		Tameside	241,875
		Total	**1,076,269**
South Manchester (operating site UHSM)	Ms Hazel Warburton	UHSM	**168,678**
		GRAND TOTAL	**3,147,277**

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

4.2. Progress

This service remains noncompliant with the objectives set out in the "Improving outcomes guidance". This is a legacy problem and there have been several attempts at resolving this by reconfiguring the service.

The latest procurement in 2014/15 was annulled by the specialised commissioning team with there being, as yet, no resolution to the issue of non-compliance. The board intends to continue to provide support where ever possible so that this is addressed.

However the board has agreed the local guidance for renal cancer and this can be found on the following link. http://manchestercancer.org/wp-content/uploads/2014/09/Renal_Guidelines.final_draft.pdf

A new protocol for the for the active surveillance of patients diagnosed with low to intermediate risk prostate cancer has also been implemented by the board, and this can be found on http://manchestercancer.org/wp-content/uploads/2014/09/Active_Surveillance_Protocol_final_draft.pdf

The remaining policies for bladder, prostate, penis and testes are currently being reviewed and until this is complete the previous GMCCN policies will remain in place. They can be found on http://manchestercancer.org/services/urology/urology-cancer-legacy-documents/

4.3. Challenges

The failure to reconfigure the service was a big disappointment to the board. Whilst it did not disrupt the board from fulfilling its role, the underlying organisational distraction of being in a competitive tendering exercise was always present.

This challenge of non-compliance will remain and with the evolving "Devolution Manchester" will have an added layer of complexity. The board intends to continue to support the commissioning process to ensure that a single standardised urological cancer service is established.

The board intends to be innovative and set standards for this service that increases participation in research, improves the patient experience and patient survival and outcomes.

Objectives for 2015/16

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

1. Develop service standards the help define the service
2. Widen stakeholder engagement by holding an open meeting
3. Agree the key clinical outcomes and outputs that will begin to define the service
4. Standardise the prostate follow up process across Greater Manchester and East Cheshire
5. 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.

5. Appendix 1 – Pathway Board meeting attendance

Include here a table outlining the attendance at each Board meeting and a summary of each member's attendance for the whole year.

NAME	ROLE	TRUST	23/04/2014	10/06/2014	24/07/2014	05/09/2014	11/11/2014	13/01/2015	04/03/2015	20/05/2015
Janet Keegan	CNS	Bolton	✓	Apologies	Apologies	✓	✓	Apols	MEETING CANCELLED	
DrGgeorge Yeung		Bolton								✓
Prof Noel Clarke	Consultant Surgeon	Christie	✓	✓	✓	✓	✓	✓	MEETING CANCELLED	Apologies
Mr Dan Burke	Consultant Surgeon	CMFT	✓	✓	✓	✓	✓	✓	MEETING CANCELLED	✓
Mr Jeremy Oates	Consultant Urologist	Mid Cheshire	Apologies	✓	✓	✓	Apologies	Apols	MEETING CANCELLED	✓
Mr J Calleary	Urology	Pennine	✓	✓	✓	✓	✓	✓	MEETING CANCELLED	Apologies
Mr Kieran O'Flynn	Urological Surgeon	SRFT	✓	✓	Apologies	✓	Apologies	Apols	MEETING CANCELLED	✓
Mr Satish Maddineni	Pathway director	Manchester Cancer	✓	✓	✓	✓	✓	✓	MEETING CANCELLED	✓
Mr Stephen Bromage	Consultant urological	SHH	✓	✓	✓	✓	✓	✓	MEETING CANCELLED	✓
Mr J Husain	Consultant Urologist	WWL	✓	✓	✓	Apologies	Apologies MR Thompson	Apols	MEETING CANCELLED	Apologies
Miss Hazel Warburton	Consultant Urologist	UHSM	Apologies Mr le Chow	✓	✓	✓	✓	Apols	MEETING CANCELLED	✓
Jane Booker	Clinical Nurse Specialist	Nursing	Apologies	✓	Apologies	✓	✓	✓	MEETING CANCELLED	✓
Maryna Lewinski	Radiologist	Diagnostics	✓	✓	✓	✓	✓	Apols	MEETING CANCELLED	✓
Mike Scott	Pathologist	Diagnostics	✓	✓	✓	✓	✓	✓	MEETING CANCELLED	Apologies
Helen Johnson	Clinical Nurse Specialist	Prostate care	✓	Apologies	✓	Apologies	✓	✓	MEETING CANCELLED	✓
Tony Elliott	Oncologist	Clinical trials	✓	✓	Apologies	✓	✓	Apols	MEETING CANCELLED	✓
Steve Elliot	GP	GP	Apologies	✓	Apologies	Apologies	Apologies	✓	MEETING CANCELLED	Apologies
Cath Briggs	GP		Apologies	✓	Apologies	✓	Apologies	Apols	MEETING CANCELLED	Apologies
TBC		Palliative care							MEETING CANCELLED	
Teresa Karran		Macmillan care	Apologies	✓	Apologies	Apologies	Apologies			
Jeanette Lyons	CNS	Oncology Nurse	Apologies	Apologies	Apologies				MEETING CANCELLED	
Anna Tran	Oncologist	Oncologist	✓	✓	Apologies	Apologies	✓	✓	MEETING CANCELLED	
Dr Thistelthwaite	Medical Oncologist							✓	MEETING CANCELLED	✓
Ted Chatt	Patient Representative							✓	MEETING CANCELLED	✓

6. Appendix 2 – Pathway Board Annual Plan 2015/16

Urology Pathway Board Annual Plan 2014-15

Pathway Clinical Director:	Mr Satish Maddineni
Pathway Board Members:	
Pathway Manager:	James Leighton
Date agreed by Pathway Board:	24th 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	Standardise the prostate follow up process across Greater Manchester and East Cheshire	Objectives 1 & 3
4	Confirming the key clinical outcomes to be measured for bladder, renal and prostate cancer	Objectives 1
5	Work with provider Trusts to co-ordinate a response to the “suspected cancer : recognition and referral” NICE guidelines	Objective 1

Objective 1: Develop service standards the help define the service

Objective:	To develop service standards the help define and govern the service
Rationale:	As part of the intended reconfiguration of Urology 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

1. **Objective 2:** Widen stakeholder engagement

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 urological 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		
Action	**Resp.**	**By (date)**
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: Standardise the prostate follow up process across Greater Manchester and East Cheshire

Objective:	To support the roll out of more community based follow up clinics for patients diagnosed with prostate cancer
Rationale:	The board is aware that there is a successful pilot has been undertaken in South Manchester into providing community based follow up clinics for patients diagnosed with prostate cancer. This pilot has been well received and is now being replicated in other parts of the city. By standardising this there will be a common agreed approach to this follow-up process.
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		
Action	**Resp.**	**By (date)**
Review community follow-up processes	Board	Jul 15
Agree a position statement on community follow-up clinics	Board	Sep 15
Draft possible follow-up protocols	Board	Jan 16
Agree follow-up processes	Board	Mar 16

Objective 4: Confirming the key clinical outcomes to be measured for bladder, renal and prostate cancer

Objective:	Confirming the key clinical outcomes to be measured for bladder, renal and prostate 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):	31/3/15
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 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		
Action	**Resp.**	**By (date)**
Draft list of outcome measures tabled at board meeting	Board	5 9 14
Final list of outcome measures agreed		7/11/14
Full commencement of routine data collection		1/1/15
Audit of completeness of data collected		31/3/15

Objective 5: Co-ordinate a response to the "suspected cancer: recognition and referral" NICE guidelines

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		
Action	**Resp.**	**By (date)**
Audit the scanning departments on primary care access	PM	Q2
Liaise with commissioners to understand possible volumes	PD	Q2
Review at board	Board	Nov 15
Develop protocol to ensure correct patients access scanning	Board	Jan 16