Greater Manchester Cancer Board Agenda

Meeting time and date: Monday 16th March 2020 3pm – 5pm

Venue: Hilton Doubletree Manchester Piccadilly, One Piccadilly Place, 1 Auburn Street, Manchester M1 3DG (Brodick Room)

Chairs: Carolyn Wilkins/ Roger Spencer

#	Item	Type	To	Lead	Time
1s	Welcome and apologies	Verbal	-		5′
2s	Minutes of the last meeting	Paper 1	Approve		5′
3s	Action log and matters arising	Paper 1	Note		5’
4s	Performance against the national CWT standards in GM	Paper 2	Approve	Lisa Galligan-Dawson	15’
5s	Long Term Plan Funding: Cancer Programme in GM	Paper 3 Presentation 1	Approve	Claire O’Rourke	15’
5.1	Lung Health Checks update	Presentation 2	Approve	Alison Jones and David Shackley	15’
5.2	Screening / national programs update	Presentation 3	Discuss	Christine Khiroya	15’
5.3	Improving Specialist Care	Presentation 4	Approve	Sarah Maynard Walker	15’
5.4	Gateway C update	Presentation 5	Info	Cathy Heaven	5’
6	Papers for information ▪ GM Cancer comms brief ▪ RDC’s ▪ Transformation projects update ▪ Gateway C ▪ QSIS	 ▪ Paper 4 ▪ Paper 5 ▪ Paper 6 ▪ Paper 7 ▪ Paper 8	 ▪ Info ▪ Info ▪ Approve ▪ Info ▪ Approve	 ▪ Anna Perkins ▪ Sarah Taylor ▪ Alison Armstrong ▪ Cathy Heaven ▪ Susi Penney	15’
7	AOB				10’

Future Meeting Dates:

16th May 3-5pm

20th July 3-5pm

Paper 1

Greater Manchester Cancer Board
Minutes and Actions

Meeting time and date: Monday 20th January 2020, 15:00 – 17:00

Venue: Hilton Doubletree Manchester Piccadilly, One Piccadilly Place, 1 Auburn Street, Manchester M1 3DG (Brodick Room)

Members present			
Name	**Role**	**Organisation/Representation**	**Attendance 2019/20**
Carolyn Wilkins (CW)	Co-Chair & Chief Executive Officer	Oldham Council / Clinical Commissioning Group	4/6
Dave Shackley (DS)	Director	GM Cancer	6/6
Claire O'Rourke (COR)	Associate Director	GM Cancer	6/6
Ian Clayton (IC)	User Involvement Rep PaBC	Macmillan User Involvement Programme	6/6
Nabila Farooq (NF)	User Involvement Rep PaBC	Macmillan User Involvement Programme	4/6
Fiona Noden (FN)	Chief Operating Officer	The Christie NHS Foundation Trust	4/6
Cathy Heaven (CMH)	Chair of Cancer Education	The Christie NHS Foundation Trust	6/6
Lisa Spencer (LS)	Director of Transformation	Salford Royal NHS Foundation Trust	5/6
Rob Bellingham (RB)	Managing Director	GM Joint Commissioning Team	5/6
Adrian Hackney (AH)	Director of Commissioning – GM Cancer Services	GM Joint Commissioning Team	3/6
Sarah Taylor (ST)	GP Lead	GM Cancer	3/6
Suzanne Lilley (SL)	Workforce Lead	GM Cancer	3/6
Tracey Vell (TV)	Primary Care Lead	GMHSCP / HIM	2/6
Susi Penney (SP)	Associate Medical Director	GM Cancer	6/6
Roger Prudham (RP)	Lead Cancer Clinician, NES	Northern Care Alliance NHS Group	4/6
Rob Bristow (RBr)	MAHSC Cancer Domain Academic Lead / Director	Manchester Cancer Research Centre	2/6
Emma Greenwood (EG)	Director of Policy and Public Affairs	CRUK	3/6
Caroline Davidson (CD)	Representing Darren Banks	Manchester NHS Foundation Trust	3/6
Beth Sharratt	Senior Project Officer	GMVCSO	1/6

In attendance		
Name	**Role**	**Organisation**
Chris Harrison (CH)	Executive Medical Director	The Christie NHS Foundation Trust
David Wright (DW)	TYA Lead Nurse & TYA Pathway Director	For GM Lead Cancer Nurses
Leah Robins (LR)	Rep for GM Chief Operating Officers	Northern Care Alliance NHS Group
Paula Daley (PD)	Macmillan User Involvement	GM Cancer
Alison Armstrong (AA)	Programme Lead	GM Cancer
Alison Jones (AJ)	Associate Director of Commissioning	GM Cancer
Stephen Jones (SJ)	Genomics Project Manager	GM Cancer
Lisa Galligan-Dawson (LGD)	Programme Director	GM Cancer
Jaqie Lavelle	Senior Business Administrator	GM Cancer
Anna Perkins	Communications and Engagement Lead	GM Cancer
Michelle Leach	Pathway Manager	GM Cancer
Barney Schofield (BS)	Director of Planning	Northern Care Alliance Group
Graham Beales (GB)	Head of Business Intelligence	GMHSCP
Fiona Blackhall (FB)	Pathway Clinical Lead – Genomics	The Christie / GM Cancer
Ryan Donaghey		Provider Federation Board
Claire McQueen		NHS Improvement
Karen Farrow	User Involvement Rep PaBC	Macmillan User Involvement Programme
Louise Sinnott	Head of Place Based Commissioning	NHS England and NHS Improvement

Apologies

Name	**Role**	**Organisation**
Roger Spencer	Co-Chair / Chief Executive	The Christie NHS Foundation Trust
Cheryl Lenney	Executive Director of Nursing	Manchester NHS Foundation Trust
Sarah Price	Interim Chief Officer	GM Health & Social Care Partnership
Gill Burrows	Medical Director	Stockport NHS Foundation Trust
Tanya Humphreys	Head of Services (Interim) for North West of England	Macmillan

Richard Preece	Director of Quality/ medicine	GM Health & Social Care Partnership

1. Welcome and Apologies	
Discussion summary	CW extended a welcome to all in attendance, members and guests. A round of introductions followed and apologies were noted.
Actions and responsibility	No further actions.

2. Minutes of the last meeting	
Discussion summary	Minutes of the meeting 28 November 2019 were discussed and agreed by members as a true record. Cathy Heaven suggested CMH is used for her initials and CH for Chris Harrison to avoid confusion.
Actions and responsibility	No further actions.

3. Action log and matters arising	
Discussion summary	The action log was briefly discussed by members of the meeting.
Actions and responsibility	CW said that the patient experience meeting is being set up. Other actions covered by the agenda. No further actions.

4. Performance against the national CWT standards in GM	
Discussion summary	Lisa Galligan-Dawson gave a presentation in support of the circulated paper and appendices. LGD highlighted the Oct/Nov position and the variation in 62-day standard performance across the system and also the position in relation to 104-day breaches, noting an improved position in November on this metric and also for breast symptomatic two-week waiting times. The priorities of the GM Cancer Waiting Times Performance & Improvement Board (P&I Board) were identified as: • Backlog clearance • Additional capacity • Time to first appointment and CaRP to 72hrs • Single diagnostic queue • System reporting Patient tracking list (PTL) reviews have been undertaken and best practice guidance is being produced. Key recommendations will also be made in terms of operational policies and diagnostic reporting. The draft Operational Policy will be circulated in February. In terms of performance data, the system now has 'one version of the truth' on Tableau.

	The backlog plan is still awaiting final data from some providers. LGD asked that when the plan is produced and shared, that implementation could commence prior to the next board, with the co-chairs sign off. This was agreed. LS questioned the governance and level sign up across providers and the plan in this respect. LGD described where the plans will be discussed in addition to the P&I Board. LN said accountability is through the COOs group, as that is where the accountability sits within organisations. RP asked whether the single diagnostic queue is exclusive to EBUS, EUS & CPEX. SP said they looking wider and looking at a suitable IT platform to cover the full range. LGD said the key will be the balance of small scale successful testing versus a big bang approach. LR clarified that the summary states this was supported by COOs but should read 'supported in principle'. IC stressed the importance of patients holding the system to account. In this, the focus has been on providers but this also needs to apply to commissioning. COR said the £92k had been secured from NHSE to support performance improvement and backlog clearance. This has to be spent before the end of March. BS highlighted the potential deterioration in short-term performance as a result of undertaking backlog clearance. SP described how this fits in the quarterly assurance process with David Levy.
Actions and responsibility	LGD to circulate the operational policy document in February. LGD to circulate the backlog clearance plan between meetings and commence implementation with CW and RS agreement on behalf of the board. COR to share details of how funding for performance improvement / backlog clearance may be accessed.

5. Genomics update and forward planning	
Discussion summary	Professor Fiona Blackhall (FB) gave a presentation. She described the pathway board, its constituent components and stressed the central involvement of service users and their influence through lived experience. From April the majority of genomic testing will be centrally commissioned via NHSE and this will be linked to the development of tariffs. Clinical anxieties have been allayed regarding the provision of clinical reports, negating the need for clinicians to interpret the results of the genomic tests. FB explained arrangements for the North West Genomic Laboratory Hub (NWGLH) and work with other alliances in the North West. The National Test Directory comprises 900 lines of tests across the majority of, but not all, cancers. The NWGLH is presently >90% compliant with the directly (ahead of other GLHs) but it is critical to be responsive, given how fast the field is

	evolving. For maximum benefits in patient outcomes, some tests need to be funded ahead of the test directory. Some of these have been supported by pharma. Pathology tests are not funded centrally. FB said there needs to be caution with respect to the use of direct to consumer tests. This is going to be built into a module for Gateway-C. The three project managers in the NWGLH have been mapping (patient) tissue pathways. Pathology information is critical to determine the right approach and to avoid delays. They have additionally mapped pathways to the laboratories that are doing particular diagnostics. Data is being obtained regarding times for sample to lab and turnaround times. A critical balance needs to be struck between timeliness of test requests and avoiding unnecessary and costly tests. DS thanked FB for the presentation and acknowledged the huge amount of progress in a single year. In response to a question from RP regarding information governance, FB said that NHSE is leading on this. Patient choice forms have been developed and are in use, allowing the data to be held in a data library. Additional work is being undertaken to enable this to be used for research. FB described the 'balancing act' between timeliness and the right care and said it is hoped that there may be some flexibility / variation in standards to accommodate this. TYA (unless sarcoma) not eligible for centralised commissioned WGS. Need to consider 'local commissioning' ahead of central in some circumstances.
Actions and responsibility	No actions identified.

6. Gateway C update	
Discussion summary	Deferred until next meeting in March.
Actions and responsibility	No actions required.

7. Improving Specialist Care - breast cancer	
Discussion summary	LGD explained the background to plans to address issues in GM breast services and the separation of the work into three phases. In the light of concerns regarding the fragility, stability and sustainability of services, phase one immediate resilience issues had largely been addressed. Services were now described as 'stabile but fragile'. The longer term plan is the implementation of the new model of care through the Improving Specialist Care Programme (ISC). Given that this implementation is at least 18 months from delivery it has been identified that a second interim phase is required to build capacity, enhance resilience, improve performance and to support the implementation of the ISC decision.

	RB added that the immediate stabilisation had resulted in revised patient flows and cost pressures that need to be addressed. RB will be chairing the task and finish group being established to take this forward through the GM Joint Commissioning Board. AH will be providing management support to the T&F group and AH has already met with Clare Garnsey, who had presented a case of need for this work at the last board, to develop the terms of reference.
Actions and responsibility	AH to establish task & finish group

8. Quality Surveillance	
Discussion summary	SP described quality surveillance programme that had replaced the previous peer review process and how this it is proposed to adapt this process in GM. The proposals have been developed with the Quality Surveillance Team (within NHSE). This clarifies responsibilities in GM and describes where the GM Cancer Board fits into this process. The GM approach introduces an interim step in the process in which GM Cancer / other compliant GM services may support and assist in addressing issues of non-compliance. This should enable improvement interventions and reduce the need for external peer reviews. The paper describes the suggested process for managing the Quality Surveillance Information System (QSIS) upload. IC asked about patient involvement is every MDT in every provider is a potential major task. SP explained how this has worked in her experience. IC stressed the importance of connectivity with the GM User Involvement Group, given the flows of patients across and between organisations. CH asked about the timeliness of the reporting of outcomes and the follow up to ensure that issues have been addressed. SP is pressing for feedback closer to the date of the review for this to be meaningful.
Actions and responsibility	SP to follow up re patient involvement and connectivity to the GM User Involvement Group.

9. Cancer scorecard	
Discussion summary	Graham Beales, Head of BI at GMHSCP attended and gave a presentation. Multiple data flows are pulled into and presented through Tableau as a single version of the truth, reflecting NHSE data. Nine out of ten GM CCGs use Tableau as the primary reporting portal and GP Federations are exploring utilising this too. The platform provides a self-service approach. GB will provide access to Tableau for those wishing to register. GB showed the key metric summary and what is behind this in board report format, by locality and the ability to view better and worse than mean and comparators. This supports decisions regarding deeper dives into problems and variation. Race charts show movement and variation over time.

	Important next steps are to develop the granularity of information available. Some changes are being made to the data sharing agreement to enable reporting at PCN and neighbourhood levels. It is expected that PCN level will be available by February with the inclusion of Eastern Cheshire by April. FN stressed the importance of being able to look at tumour groups and pathways of care as patient flows across organisations, to see where patients are well served or not. IC questioned how much time the GM Cancer Board will dedicate to performance and actions to address this, if the aspiration to world class outcomes is to be realised. He added that to date, the system had not demonstrated much traction in some of the areas of underperformance and tackling these. IC guarded against comparing self with self. GB clarified regarding the board report with respect to performance will come from LGD and then any deep dive may be what comes to the GMCB. When patient level data is available, we will be able to drill down to age, gender post codes. LGD stressed the importance of looking forward rather than an 'after the event' focus. RP asked about the potential for joining up with other data e.g. air pollution, fast food etc. GB acknowledged some opportunities exist but the quality of data would be critical to this being meaningful. CH raised the importance of answering questions and not simply exploring hypotheses through the data. DS said that the board snapshot needs to be more than performance to include outcomes. The theming of boards will enable the snapshot to be linked to these. As survival data is dated, the use of proxy metrics in lieu of the measures that 'take time to land' was recognised.
Actions and responsibility	GB to continue the develop work as presented.

10. Papers for information	
Discussion summary	DS highlighted a number of points and drew members attention to: a) The NHSE update report and national picture summary. b) GM Cancer 2019 Annual Report. The plan is to publish this on World Cancer Day, 4 February 2020. If members identify omissions or inaccuracies please raise these with DS or COR by 31 January 2020. c) Research Annual Report – 'a sister paper' to the GM Cancer Annual Report. A huge amount of activity to report on and the two documents combined, demonstrating the alignment of research, innovation and clinical practice will place GM in a strong position to secure research grants. A research update will be brought to a future Cancer Board. d) Prehab for Cancer received significant positive media attention over the festive season, both national television and newspapers.
Actions and responsibility	No actions.

11. AOB	
Discussion summary	a) SP reported that new guidance streamlining multi-disciplinary teams (MDT) had recently been published. SP agreed to ensure this is circulated and will be working on implementing this guidance in GM.
Actions and responsibility	SP to ensure new MDT guidance is shared.

12. Future Meeting Dates	
Discussion summary	CW thanked the board members and guests for attending. The next meeting is scheduled for: Monday 16th March 2020, 15:00 -17:00 at The Hilton Doubletree
Actions and responsibility	No further actions.

Action Log
Prepared for the 16th March meeting of the board

Log No.	AGREED ON	ACTION	STATUS
11.19	28th November 2019	COR to set up a patient experience group to coordinate and communicate actions to improve patient experience across GM & EC COR is in the process of setting up	Patient experience to be agreed 30/06/2020 at personalised care event
1.20	20th January 2020	**Performance against the national CWT standards in GM:** LGD to circulate the operational policy document in February	**Complete:** Operational policy document - circulated
2.20	20th January 2020	**Performance against the national CWT standards in GM:** LGD to circulate the backlog clearance plan between meetings and commence implementation with CW and RS agreement on behalf of the board.	Backlog clearance plan to be discussed with CW & RS on 06.03.20
3.20	20th January 2020	**Performance against the national CWT standards in GM**: COR to share details of how funding for performance improvement / backlog clearance may be accessed.	**Complete:** LG shared details of the funding for performance & improvement
4.20	20th January 2020	**Improving Specialist Care - breast cancer** AH to establish task & finish group	**Complete:** The Task and Finish Group has been established and has already met twice
5.20	20th January 2020	**Quality Surveillance:** SP to follow up re patient involvement and connectivity to the GM User Involvement Group.	**Complete:** The document has been circulated to Cancer Commissioning Managers and Trust cancer Managers.
6.20	20th January 2020	**Cancer Scorecard:** GB to continue the develop work as presented.	**Complete:** To discuss Agenda item 6 TF update
7.20	20th January 2020	**AOB:** SP to ensure that the new MDT guidance is shared.	**Complete:** SP shared the MDT guidance

Paper 2

Cancer Waiting Times Performance Update

Title of paper:	Cancer Waiting Times Performance Update
Purpose of the paper:	To advise the Board of the current Cancer Waiting Times performance for December 2019, and Quarter 3 19/20 along with an update on the work being undertaken to improve this position.
Summary outline of main points / highlights / issues	• 62 day RTT target (and others) continue to underachieve • There has been an improvement in the 2ww and unofficial Day 7 performance • To provide an update on the Cancer waiting Times Performance & Improvement Board's agreed programme of work • Provide a summary of the other work being undertaken to drive improvement in performance
Consulted	• The appendices have been approved discussed at the Cancer Waiting Times Performance & Improvement Board. They were agreed, with the caveat of additional items being added by Pennine and MFT, which are now included in the plan. Documents are agreed in principle by the Chief Operating Officers Forum
Author of paper and contact details	**Name:** Lisa Galligan-Dawson **Title:** Programme Director - Cancer Performance, GM Cancer **Email:** lisa.galligandawson@christie.nhs.uk

1 Background and Context

Following the GM Cancer Boards in November 2019 and January 2020, this paper provides the Board with an update on the key areas of Cancer Waiting Times performance and the programme of work being undertaken to improve the waiting times standards, and achieve the GM ambitions relating to timely diagnosis and treatment, and reducing variation.

2 Key discussion points

Cancer Waiting Times Performance – December 2019 & Quarter 3 2019/20	
	62 day provider performance for GM&C in December was 76.19% compared with 75.85% in November and 73.98% in October 2019. 62 day CCG performance was 75.43% in December compared to 74.19% November and 74.75% in October. The 62 day performance in Q3 was 75.60% for GM&C Providers and 75.43% for GM&C CCGs, showing deterioration as forecasted. The overall 2ww standard for GM&C providers has been achieved in December 2019, at 95.2%; this is the second consecutive month the standard has achieved, and it is the best performing individual month since February 2018. It should also be noted that this is the first time in over 12 months that each individual Trust has achieved the standard. Importantly, performance at specialty level has improved, with only two tumour sites not individually achieving the 2ww standard – Gynaecology and Upper GI. The 2ww standard for GM&C CCGs has also achieved in December 2019 at 95.19%. For Quarter 3, the 2ww standard for GM&C providers and CCGs has achieved at 93.12% and 93.24% respectively. This is the first quarter to achieve since Q4 18/19. Individual Provider / CCG 2ww and 62 day performance for December 19 and Q3, along with a summary of the other standards at GM and GM&C can be found in Appendix 1. Whilst it is essential to monitor individual Trust and CCG performance, as previously discussed, the way in which performance breaches and compliances are allocated does not fully align with the way in which pathways are delivered. It has therefore been agreed that it would be beneficial to increase the focus on delivery as a system, and at pathway level. With this in mind, the following aspect of this paper focuses on pathway performance.

The table below describes the GM&C 62 day performance by tumour site.

	2016/17	2017/18				2018/19				2019/20		
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Acute leukaemia	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	77.78%	100.00%	100.00%	100.00%
Brain/Central Nervous Sy..		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	75.00%	100.00%	
Breast	98.55%	96.39%	96.12%	97.26%	96.31%	94.87%	95.11%	95.86%	91.15%	92.56%	95.88%	92.44%
Children's								100.00%	100.00%		100.00%	75.00%
Gynaecological	79.17%	82.91%	80.27%	76.47%	76.27%	69.57%	70.90%	68.61%	61.89%	55.07%	57.09%	57.14%
Haematological (Excludin..	77.78%	74.50%	76.74%	82.48%	83.08%	80.50%	76.19%	86.19%	82.08%	74.55%	73.56%	82.20%
Head & Neck	86.62%	88.54%	89.61%	87.89%	84.44%	77.03%	79.31%	71.95%	77.32%	82.82%	82.86%	69.17%
Lower Gastrointestinal	80.22%	79.15%	81.82%	77.45%	78.59%	67.63%	66.82%	63.19%	72.43%	67.92%	67.12%	68.51%
Lung	83.52%	82.45%	81.95%	81.91%	80.73%	71.53%	79.82%	79.71%	71.09%	59.62%	67.09%	59.58%
Other	78.13%	59.38%	84.21%	87.76%	57.89%	72.22%	62.22%	75.00%	70.73%	68.63%	59.46%	46.88%
Sarcoma	67.86%	83.33%	54.17%	60.71%	75.00%	76.92%	48.57%	41.03%	70.00%	27.27%	58.33%	48.57%
Skin	97.23%	98.66%	94.97%	95.32%	95.30%	95.43%	93.54%	92.60%	92.92%	96.05%	91.79%	92.63%
Testicular	100.00%	100.00%	96.55%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.00%	100.00%
Upper Gastrointestinal	66.15%	58.48%	68.68%	74.27%	68.50%	69.87%	67.76%	65.64%	66.22%	65.00%	71.39%	59.94%
Urological (Excluding Test..	88.16%	86.58%	91.44%	87.86%	86.38%	81.21%	80.77%	79.46%	79.04%	82.07%	78.91%	78.71%

In Q3 there were 531 breaches of the 62 day standard.

The performance by percentage is listed in the table, but the specialties accounting for the highest number of breaches were:

Tumour site	Number of breaches
Lung	116
Urology	101.5
Lower GI	91
Upper GI	68.5
Gynaecology	58.5

The tables below show our 7 day performance by provider. As this is not a formal measure we already have the January data.

TRUST	Q1				Q2				Q3				Q4 (Jan 20 only)			
	< 7	> 7	T	%	< 7	> 7	T	%	< 7	> 7	T	%	< 7	> 7	T	%
Tameside	759	1973	2732	27.8%	746	2182	2928	25.5%	758	2214	2972	25.5%	437	515	952	45.9%
WWL	724	2546	3270	22.1%	863	2423	3286	26.3%	674	2528	3202	21.0%	440	556	996	44.2%
Pennine	1169	6455	7624	15.3%	1830	5744	7574	24.2%	1671	6355	8026	20.8%	884	1729	2613	33.8%
Stockport	619	2110	2729	22.7%	600	1832	2432	24.7%	627	1864	2491	25.2%	305	454	759	40.2%
Central	905	2507	3412	26.5%	850	2863	3713	22.9%	911	2712	3623	25.1%	282	718	1000	28.2%
South	853	3426	4279	19.9%	927	3801	4728	19.6%	1097	3810	4907	22.4%	628	1000	1628	38.6%
Bolton	1371	1538	2909	47.1%	1283	1762	3045	42.1%	1648	1436	3084	53.4%	591	330	921	64.2%
Mid Cheshire	1060	1922	2982	35.5%	1461	1785	3246	45.0%	1447	1431	2878	50.3%	550	425	975	56.4%
East Cheshire	386	1243	1629	23.7%	466	1259	1725	27.0%	445	1241	1686	26.4%	221	315	536	41.2%
Salford	1084	3031	4115	26.3%	988	3377	4365	22.6%	1352	2726	4078	33.2%	511	640	1151	44.4%
Grand Total	**8930**	**26751**	**35681**	**25.0%**	**10014**	**27028**	**37042**	**27.0%**	**10630**	**26317**	**36947**	**28.8%**	**4849**	**6682**	**11531**	**42.1%**

42% of patients referred on a suspected cancer in GM&C were seen in 7 days in January, this is the best performance in well over 12 months.

Day 7 Performance by tumour site

Referral Type	Q1				Q2				Q3				Q4 (Jan 20 only)			
	< 7	> 7	T	%	< 7	> 7	T	%	< 7	> 7	T	%	< 7	> 7	T	%
Brain/ CNS	229	55	284	80.6%	158	67	225	70.2%	201	48	249	80.7%	69	20	89	77.5%
Breast	573	6151	6724	8.5%	1255	5210	6465	19.4%	1054	6033	7087	14.9%	908	1384	2292	39.6%
Childrens	62	99	161	38.5%	59	62	121	48.8%	47	47	94	50.0%	19	17	36	52.8%
Gynaecology	917	2399	3316	27.7%	1207	2137	3344	36.1%	1138	2145	3283	34.7%	530	526	1056	50.2%
Haematology	145	290	435	33.3%	148	286	434	34.1%	165	261	426	38.7%	60	70	130	46.2%
Head & Neck	1463	2103	3566	41.0%	1277	2559	3836	33.3%	1416	2464	3880	36.5%	589	600	1189	49.5%
Lower GI	1416	5840	7256	19.5%	1755	6040	7795	22.5%	1923	5672	7595	25.3%	639	1653	2292	27.9%
Lung	875	381	1256	69.7%	985	305	1290	76.4%	946	441	1387	68.2%	363	172	535	67.9%
Other	60	89	149	40.3%	36	86	122	29.5%	47	113	160	29.4%	10	39	49	20.4%
Sarcoma	32	124	156	20.5%	39	143	182	21.4%	58	124	182	31.9%	13	44	57	22.8%
Skin	865	5005	5870	14.7%	738	6079	6817	10.8%	912	4847	5759	15.8%	764	775	1539	49.6%
Testicular	61	93	154	39.6%	41	27	68	60.3%	43	25	68	63.2%	19	4	23	82.6%
Upper GI	1064	2516	3580	29.7%	1015	2568	3583	28.3%	1055	2635	3690	28.6%	455	808	1263	36.0%
Urology	1168	1606	2774	42.1%	1301	1459	2760	47.1%	1625	1462	3087	52.6%	411	570	981	41.9%
Grand Total (Exc B	**8930**	**26751**	**35681**	**25.0%**	**10014**	**27028**	**37042**	**27.0%**	**10630**	**26317**	**36947**	**28.8%**	**4849**	**6682**	**11531**	**42.1%**
Grand Total (Inc B	**9244**	**29851**	**39095**	**23.6%**	**10502**	**29406**	**39908**	**26.3%**	**11036**	**28732**	**39768**	**27.8%**	**5110**	**7360**	**12470**	**41.0%**
Breast Symptomat	314	3100	3414	9.2%	488	2378	2866	17.0%	406	2415	2821	14.4%	261	678	939	27.8%

Faster Diagnosis

The Day 28 standard continues to be recorded in shadow format. Performance and compliance rates for December have been provided by Cadeas. The way in which these reports have been complied are based on average referral numbers and therefore are not necessarily as accurate as some Trust's internal reporting. There is no official NHSE data available.

FDS Compliance by Provider

	July 2019		August 2019		September 2019		October 2019		November 2019		December 2019	
	EndDate Comple..	Comply	EndDate Comple..	Comply	EndDate Comple..	Comply	EndDate Comple..	Comply	EndDate Comple..	Comply	EndDate Comple..	Comply
BFT	1,018	86.42%	926	78.61%	912	77.42%	976	82.85%	947	80.39%	918	77.93%
ECT	478	78.00%	442	72.12%	491	80.12%	477	77.84%	560	91.38%	496	80.94%
MCFT	942	85.35%	649	58.80%	761	68.95%	946	85.71%	759	68.77%	765	69.31%
MUFT	1,838	56.75%	1,834	56.63%	1,633	50.42%	1,904	58.79%	1,796	55.45%	1,610	49.71%
PAHT			1	0.04%			3	0.11%	1	0.04%	3	0.11%
SFT	930	100.00%	712	87.45%	732	89.91%	842	100.00%	792	97.28%	734	90.15%
SRFT	1,319	91.10%	1,222	84.40%	1,317	90.96%	1,430	98.77%	1,208	83.44%	957	66.10%
TGIFT	851	78.47%	812	74.87%	723	66.67%	717	66.11%	756	69.71%	649	59.84%
WWLFT	898	75.24%	915	76.67%	823	68.96%	1,121	93.93%	1,019	85.38%	871	72.98%

FDS Performance by Provider

	July 2019		August 2019		September 2019		October 2019		November 2019		December 2019	
	Within 28 Days	Within %	Within 28 Days	Within %	Within 28 Days	Within %	Within 28 Days	Within %	Within 28 Days	Within %	Within 28 Days	Within %
BFT	886	87.0%	826	89.2%	795	87.2%	849	87.0%	795	83.9%	802	87.4%
ECT	334	69.9%	317	71.7%	373	76.0%	377	79.0%	412	73.6%	343	69.2%
MCFT	856	90.9%	601	92.6%	638	83.8%	791	83.6%	642	84.6%	656	85.8%
MUFT	1,566	85.2%	1,523	83.0%	1,363	83.5%	1,635	85.9%	1,492	83.1%	1,339	83.2%
SFT	461	49.6%	367	51.5%	360	49.2%	491	58.3%	431	54.4%	411	56.0%
SRFT	998	75.7%	869	71.1%	930	70.6%	971	67.9%	969	80.2%	757	79.1%
TGIFT	752	88.4%	687	84.6%	620	85.8%	626	87.3%	608	80.4%	540	83.2%
WWLFT	708	78.8%	667	72.9%	554	67.3%	842	75.1%	788	77.3%	676	77.6%

Cancer Waiting Times Performance & Improvement Board – System wide Improvement Initiatives	
	Actions 1, 2 and 3 in this work programme relate to the creation of a plan to reduce the backlog numbers improve the times to diagnostics and the first appointment. Information has been collated from all providers in relation to the current gap. An activity plan has now been developed and costed, and has been agreed as the foundation for system wide improvement through the GM Cancer Waiting Times and Improvement Board. All Chief Operating Officers have been sighted on this plan. Work is under way to agree funding for the plan, and this will then be operationalised and monitored. See Appendix 2 Actions 4 and 5 are to reduce variation and to enhance collaborative working. The shift towards monitoring pathways has commenced, and the Steering Group and sub groups relating to single queue diagnostics have been established. The scope of this initiative has been extended to include CT guided lung biopsy.

Transactional Improvement Work Summary	
PTL	The PTL management reviews in GM&C and including high performing organisations in Cheshire & Merseyside have been completed and a GM wide summary of Best Practice and key recommendations has been produced and circulated to key stakeholders for comments.
Operational standards / policy	A draft Operational Policy, including key operational standards, monitoring and roles and responsibilities has also being drafted and circulated for comments.
Data	There is a requirement for us to develop additional KPIs and measurement standards, as until the existing cohort of 62 day breach patients is cleared, and we have delivered the additional activity needed to clear this backlog, the end performance position will not improve. Therefore, manging these key measures underneath is becoming essential for proactive management. Data is held only by the providers and so a workshop with Cancer and BI Managers took place at the end of January. A summary of the work programme that has been agreed can be found at Appendix 3. It has been agreed that data flows will be in place during March with the first live information on backlogs, PTL size and shape and Radiology being available for the start of Q1.
Bespoke initiatives	Training and engagement sessions are planned at Stockport, along with a bespoke resilience, team building and change management event for the provider cancer management teams. Wider training is also being scoped in collaboration with NHSI.
Summary	A significant amount of proprietary work has been undertaken; ***key to improvement in delivery is linked firmly with the plan in Appendix 2.*** However, many of these are step change / non recurrent items. Further work and investment will be required to make the improvement sustainable.

Revised Cancer Waiting Times Guidance	
	Draft guidance version 10.1 has been issued for consultation. Feedback has been collated and returned to NHSE. Once the final guidance is released this will be shared, and a performance impact assessment completed.

3 Next steps

It is essential that we move to the implementation phase of the recovery plan as soon as possible, which will require time and resource commitment from all areas, in particular the providers.

4 Recommendation, requests / support required of the Board

The GM Cancer Board is asked to support this programme of work and facilitate the time, commitment and focus needed to deliver the improvement plan.

Appendix 1

2ww performance – December 2019 and Q3 19/20

Seen within 2 weeks of referral by Trust
December 2019

	Total	Within Target	After Target	Performance
Bolton FT	950.0	929.0	21.0	97.79%
EC	516.0	502.0	14.0	97.29%
MC	885.0	861.0	24.0	97.29%
MFT	2,693.0	2,520.0	173.0	93.58%
PAHT	2,471.0	2,378.0	93.0	96.24%
SRFT	1,197.0	1,115.0	82.0	93.15%
Stockport FT	782.0	743.0	39.0	95.01%
T&G IFT	933.0	898.0	35.0	96.25%
WWL	927.0	865.0	62.0	93.31%
GMEC	11,354.0	10,811.0	543.0	95.22%
GM	9,953.0	9,448.0	505.0	94.93%

Seen within 2 weeks of referral by CCG
December 2019

	Total	Within Target	After Target	Performance
BDL	746.0	724.0	22.0	97.05%
BUR	682.0	651.0	31.0	95.45%
EC	658.0	643.0	15.0	97.72%
HMR	819.0	785.0	34.0	95.85%
MAN	1,924.0	1,785.0	139.0	92.78%
OLD	860.0	836.0	24.0	97.21%
SAL	748.0	724.0	24.0	96.79%
STO	1,206.0	1,139.0	67.0	94.44%
T&G	910.0	872.0	38.0	95.82%
TRA	891.0	840.0	51.0	94.28%
WIG	986.0	929.0	57.0	94.22%
GMEC	10,430.0	9,928.0	502.0	95.19%
GM	9,772.0	9,285.0	487.0	95.02%

Seen within 2 weeks of referral by CCG
Q3 2019/20

	Total	Within Target	After Target	Performance
BOL	2,505.0	2,414.0	91.0	96.37%
BUR	2,250.0	2,013.0	237.0	89.47%
EC	2,159.0	2,071.0	88.0	95.92%
HMR	2,599.0	2,404.0	195.0	92.50%
MAN	6,174.0	5,681.0	493.0	92.01%
OLD	2,719.0	2,601.0	118.0	95.66%
SAL	2,645.0	2,410.0	235.0	91.12%
STO	3,727.0	3,279.0	448.0	87.98%
T&G	2,926.0	2,807.0	119.0	95.93%
TRA	2,813.0	2,636.0	177.0	93.71%
WIG	3,330.0	3,179.0	151.0	95.47%
GMEC	33,847.0	31,495.0	2,352.0	93.05%
GM	31,688.0	29,424.0	2,264.0	92.86%

Seen within 2 weeks of referral by Trust
Q3 2019/20

	Total	Within Target	After Target	Performance
Bolton FT	3,062.0	2,935.0	127.0	95.85%
EC	1,641.0	1,545.0	96.0	94.15%
MC	2,872.0	2,809.0	63.0	97.81%
MFT	8,512.0	7,967.0	545.0	93.60%
PAHT	7,821.0	7,372.0	449.0	94.26%
SRFT	4,243.0	3,409.0	834.0	80.34%
Stockport FT	2,460.0	2,357.0	103.0	95.81%
T&G IFT	3,012.0	2,892.0	120.0	96.02%
WWL	3,199.0	3,046.0	153.0	95.22%
GMEC	36,822.0	34,332.0	2,490.0	93.24%
GM	32,309.0	29,978.0	2,331.0	92.79%

62 day performance – December 2019 and Q3 19/20

Treated within 62 Days from referral to first treatment by Trust
December 2019

	Total	Within Target	After Target	Performance
Bolton FT	50.0	42.5	7.5	85.00%
CHR	71.0	58.5	12.5	82.39%
EC	19.5	14.0	5.5	71.79%
MC	51.5	45.0	6.5	87.38%
MFT	161.5	109.0	52.5	67.49%
PAHT	138.0	91.0	47.0	65.94%
SRFT	68.5	61.0	7.5	89.05%
Stockport FT	52.0	36.0	16.0	69.23%
T&G IFT	46.5	38.0	8.5	81.72%
WWL	55.5	49.0	6.5	88.29%
GMEC	714.0	544.0	170.0	76.19%
GM	643.0	485.0	158.0	75.43%

Treated within 62 Days from referral to first treatment by CCG
December 2019

	Total	Within Target	After Target	Performance
BOL	53.0	45.0	8.0	84.91%
BUR	45.0	32.0	13.0	71.11%
EC	35.0	25.0	10.0	71.43%
HMR	50.0	31.0	19.0	62.00%
MAN	88.0	65.0	23.0	73.86%
OLD	62.0	46.0	16.0	74.19%
SAL	42.0	34.0	8.0	80.95%
STO	77.0	57.0	20.0	74.03%
T&G	57.0	44.0	13.0	77.19%
TRA	66.0	50.0	16.0	75.76%
WIG	72.0	59.0	13.0	81.94%
GMEC	647.0	488.0	159.0	75.43%
GM	612.0	463.0	149.0	75.65%

Treated within 62 Days from referral to first treatment by Trust
Q3 2019/20

	Total	Within Target	After Target	Performance
Bolton FT	174.0	147.0	27.0	84.48%
CHR	247.0	197.0	50.0	79.76%
EC	82.0	55.5	26.5	67.68%
MC	203.0	176.0	27.0	86.70%
MFT	499.0	335.0	164.0	67.13%
PAHT	425.5	283.5	142.0	66.63%
SRFT	211.0	175.5	35.5	83.18%
Stockport FT	182.0	126.5	55.5	69.51%
T&G IFT	143.5	122.5	21.0	85.37%
WWL	175.5	152.5	23.0	86.89%
GMEC	2,342.5	1,771.0	571.5	75.60%
GM	2,057.5	1,539.5	518.0	74.82%

Treated within 62 Days from referral to first treatment by CCG
Q3 2019/20

	Total	Within Target	After Target	Performance
BOL	193.0	155.0	38.0	80.31%
BUR	159.0	113.0	46.0	71.07%
EC	148.0	113.0	35.0	76.35%
HMR	161.0	116.0	45.0	72.05%
MAN	304.0	203.0	101.0	66.78%
OLD	160.0	114.0	46.0	71.25%
SAL	133.0	102.0	31.0	76.69%
STO	260.0	197.0	63.0	75.77%
T&G	163.0	130.0	33.0	79.75%
TRA	180.0	132.0	48.0	73.33%
WIG	219.0	180.0	39.0	82.19%
GMEC	2,080.0	1,555.0	525.0	74.76%
GM	1,932.0	1,442.0	490.0	74.64%

Additional Performance Measures – December 2019 and Q3 19/20

Combined Trust Performance
December 2019

	GM	GMEC
Seen within 2 weeks of referral - Breast Sympomatic	79.01%	80.23%
Treated < 31 Days Subsequent Treatment - Anti-cancer drug	100.00%	100.00%
Treated < 31 Days Subsequent Treatment - Radiotherapy	99.80%	99.80%
Treated < 31 Days Subsequent Treatment - Surgery	98.05%	98.17%
Treated < 31 Days to First Treatment	97.41%	97.34%
Treated within 62 Days from consultant upgrade to first treatment	84.83%	85.16%
Treated within 62 Days from national screening to first treatment	83.59%	85.31%

Combined CCG Performance
December 2019

	GM	GMEC
Seen within 2 weeks of referral - Breast Sympomatic	78.56%	78.94%
Treated < 31 Days Subsequent Treatment - Anti-cancer drug	100.00%	100.00%
Treated < 31 Days Subsequent Treatment - Radiotherapy	99.73%	99.76%
Treated < 31 Days Subsequent Treatment - Surgery	96.74%	97.04%
Treated < 31 Days to First Treatment	97.42%	97.41%
Treated within 62 Days from consultant upgrade to first treatment	83.90%	84.78%
Treated within 62 Days from national screening to first treatment	82.65%	82.52%

Combined Trust Performance
Q3 2019/20

	GM	GMEC
Seen within 2 weeks of referral - Breast Sympomatic	79.39%	80.40%
Treated < 31 Days Subsequent Treatment - Anti-cancer drug	99.68%	99.68%
Treated < 31 Days Subsequent Treatment - Radiotherapy	99.81%	99.81%
Treated < 31 Days Subsequent Treatment - Surgery	97.51%	97.63%
Treated < 31 Days to First Treatment	96.77%	96.68%
Treated within 62 Days from consultant upgrade to first treatment	81.56%	82.06%
Treated within 62 Days from national screening to first treatment	83.22%	84.90%

Combined CCG Performance
Q3 2019/20

	GM	GMEC
Seen within 2 weeks of referral - Breast Sympomatic	79.08%	79.09%
Treated < 31 Days Subsequent Treatment - Anti-cancer drug	99.44%	99.49%
Treated < 31 Days Subsequent Treatment - Radiotherapy	99.84%	99.78%
Treated < 31 Days Subsequent Treatment - Surgery	97.36%	97.44%
Treated < 31 Days to First Treatment	96.97%	96.94%
Treated within 62 Days from consultant upgrade to first treatment	81.21%	81.89%
Treated within 62 Days from national screening to first treatment	81.95%	82.37%

Appendix 2 – See separate attachment

LGD Backlog Clearance Analysis - I

Appendix 3 – Data Work stream Summary

In summary we agreed the following key principles:

- In order to enable greater management of pathways that span across multiple organisations, and changing the focus of reporting on these rather than individual provider or CCG performance we agreed that visibility of key pathway milestones was required
- In order to move us back to more proactive management we need data to be able to help us look forward, not just back at published data which is released 6 weeks after upload
- To enable us to monitor pathway and performance improvement regular visibility of backlogs, PTL size / shape is essential
- To make the best use of time and resources, some of the existing reports which are manually produced should be automated
- One version of the Truth is essential, and that system wide use of the tableau information will enable everyone to access data impacting their pathways and performance in a clear and transparent manner.

A great deal of work has been undertaken recently on Cancer information on Tableau. Some final amendments are being made to the performance reports on there which are expected to be completed in the next few weeks.
The reporting will give us:

- Performance against all the measures. That can be filtered by Trust, by CCG, at GM and GM&C level for each month. (At GM or GM&C level we will be able to see all providers or all CCGs for comparison, for each of the measures, so we can see how the total performance is broken down)
- Finalised quarterly reports (as per NHSE) but with the ability to look at All Trusts or CCGs together, to give a full overview, and the ability to look at tumour specific reports
- Ability to compare individual performance again peer sites
- Ability to look at performance and quality measures together by speciality / by provider / by CCG
- Ability to lift performance reports on key areas for all Board and Performance Reports. Reporting the monthly position which is important, but also the quarterly position which is the 'official' measure

There are a number of other reports available, the above just highlights the key CWT performance reports.

We agreed that whilst there is a lot of additional work to do, the following were the items that we prioritised as we believed that they will have the most impact in the short term and therefore are our key focus for work within Q4.

- Visibility over waiting times for all diagnostics across all providers – (radiology, endoscopy, & specialist diagnostics) that is regularly updated, to give real time data and the ability to respond quickly to challenges. It was agreed that this would help identify individual issues affecting specific areas of deliver, and wider system wide challenges.
  It was agreed that we should report by modality, by tumour site (who referred) and by the type of scan etc. CTC, Brain MR etc.
- Referral information by speciality / tumour site across all providers and CCGs to be available in real time, to enable a quicker response to the recipient Trusts, to deal with spikes in activity and greater forward planning for the treating Trusts in anticipating more accurately future capacity needs
- Reporting on histopathology across the region in terms of diagnostic reporting and post treatment reporting, by tumour site and provider. This can then be linked to pathway delivery across the region particularly where pathology is reported on behalf other organisations
- Creation of automated data on PTL size, shape, backlog to proactively manage pathways, and to enable the tracking of backlog clearance. This should be available at individual provider level, and by pathway across the region. To enable visibility of key issues in pathways, such as a rising number of untreated patients in Lung for example.
- Automate some of the existing reports in use, to enable precious cancer management resources to be released. This includes having a portal / upload space so that predicted performance can be monitored weekly rather than monthly, and can reflect 'in system' performance, and expected performance. This will automate Day 7 performance reporting, and allow reporting for first OPA at different time bands

dependent on our needs. There will be tumour specific data for pathway boards that will be available automatically from Tableau

- Breach analysis. The milestone wait pathway analyser can be placed on the portal for each trust to update – this will then create cross provider breach reviews against key milestone waits. This should link with the data required for the BTPs and Faster Diagnosis standards. In the shorter term until this is in place, data will be collated more simplistically, but will avoid manual calculation.

Next steps:

- We agreed that PTL size, shape and Backlog reporting could be delivered by generating a daily upload of data from Trusts. Provider BI teams in attendance agreed this could be automated and relatively straight forward to complete. A script has been written which will be shared with the GM BI team. The final version can then be issued to all COO and BI teams
- Data sharing agreement to be checked by GM BI team and any amendments provided for sign off by CCGs and Providers
- Radiology reporting script has already been created. This is to be shared with the GM BI team for review and any necessary amendments. Again, this will then be shared with COOs and provider BI teams

Paper 3

Long Term Plan funding-GM Cancer

Name of Meeting:	**Long Term Plan funding-GM Cancer**	
Date of Meeting:	16th March 2020	
Title of paper:	Long Term Plan (LTP) Cancer Funding	
Purpose of the paper:	The purpose of this report is to provide GM Cancer board with an update on GM Cancer funding for Transformation funded (TF) projects 19/20 and LTP funding to deliver this programme of work for 20/21 and beyond	
Reason for Paper: *Please tick appropriate box*	✓	***Decision***
		Discussion
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes	The paper outlines the delivery of improved patient outcomes in Greater Manchester as set out in the national Long Term Plan (LTP) for cancer from NHS England	
Improved patient experience	The delivery of the LTP cancer will improve patient experience for cancer patients and detailed in GM Cancer Annual report 2020 and GM cancer Plan.	
Reducing inequality	The delivery of the LTP will reduce inequality by working with the whole Cancer system in GM to ensure all cancer patients have access to high quality cancer services.	
Minimising variation	The delivery of the LTP for Cancer will reduce unnecessary variation including standardising many areas of practice and developing more single GM cancer services. This is delivered in GM by working with patients, providers and localities to monitor this and the evaluate success.	
Operational / financial efficiency	Delivery of the LTP for cancer also enables significant improvements to be made to deliver CWT standards across GM and this is monitored via GM Cancer as the alliance. Delivery of TF projects and LTP funded programmes of work and financial impact will be monitored through GM Cancer assurance board, cancer board and through NHSE.	
Author of paper and contact details	**Name:** Claire O'Rourke **Title:** Associate Director – GM Cancer **Email:** claire.orourke@christie.nhs.uk	

GMCA GREATER MANCHESTER COMBINED AUTHORITY
NHS in Greater Manchester
Greater Manchester Cancer

1.1 Greater Manchester (GM) Cancer works on behalf of the cancer system in Greater Manchester and Eastern Cheshire (GM&EC) as the 'integrated cancer system' to transform cancer services and outcomes. GM Cancer is the Cancer Alliance for GM and works on behalf of NHS England (NHSE) and the GM Health and Social Care Partnership (GMH&SCP) to deliver the Long Term Plan for cancer over the next 5 years on behalf of NHSE.

1.2 NHSE has stipulated that Cancer Alliance core teams are expected to lead and deliver the specific requirements of the LTP over the next 5 years, both in operational performance and financial delivery. The core team must be able to influence and lead transformation and delivery of the LTP and must have specifically:

- A leadership team, as per the national guidelines;
- Dedicated capacity to lead delivery of the Alliance's major programmes of work;
- Lead communications and engagement activities, including patient and public engagement;
- Deliver financial, reporting and programme management requirements;
- Undertake local analytical work as required including reporting and carrying out (or commissioning) local evaluations.

1.3 National Cancer Alliance 5 Year Planning guidance released in July 2019 states that the Long Term Plan sets 'two bold ambitions for improving cancer outcomes'. These build on and accelerate the significant progress already made through delivery of the recommendations of the Independent Cancer Taskforce (2015):

- By 2028, 55,000 more people will survive cancer for five years or more each year;
- By 2028, 75% of people will be diagnosed at an early stage (stage one or two)

The LTP Implementation Framework states that cancer alliances will need to set out how the plans will address unwarranted variation, improve patient experience and be supported by appropriate workforce and includes reference to the development and implementation of a quality of life metric, to be used to inform cancer service improvements.

1.4 Before the publication of the LTP for Cancer, GM Cancer had already developed a comprehensive cancer plan in 2017, aligned with the Taking Charge programme of the

HSCP:https://gmcancerorguk.files.wordpress.com/2016/08/achieving-world-class-cancer-outcomes-in-gm-v1-0-final-02-2017.pdf

1.5 In 2018 GM Cancer was asked by GMH&SCP to identify its 'priority 1 projects' aligned with the NHS England planning guidance and were provided with £10m of transformation funding to take these forward. This funding did not support the full delivery of the GM Cancer plan; therefore several key programmes of work have not been delivered at present. Each of the priority 1 projects commenced in late 2018. Funding to support the delivery of these projects is available until 31/3/2021. GM cancer has developed a process of reviewing the sustainability of each of the priority 1 projects with CCGs and providers through the development of business cases. The CCG Director of Commissioning and Chief Finance Officer has been engaged throughout and continue to be. Priority 1 projects which have been funded:

- Cancer Intelligence
- Best time pathways: Lung, Colorectal, Prostate
- Prehab4Cancer
- Living with and beyond cancer (cancer care co-ordinators)
- CURE (7 sites in GM)
- Education
- Goals of Care Initiative
- Stratified follow up
- Core team and corporate costs to support delivery

As well as leading the programme of work for the transformation funded projects, GM Cancer has led the development of the response to the LTP and is establishing a programme of work to support its delivery. A 'plan on a page' summary was approved by the Cancer Board on 16th September 2019 and submitted, along with the detailed plan to GMH&SCP:

1.6 November 2019 the Partnership Executive Board (PEB) recognised that the cancer programme had received less funding over the first four years of devolution. It was approved that cancer would be a priority in the allocation of resources from LTP funding. As such, funding nominally allocated for cancer programmes in the national allocations would be protected, both in terms of 2019/20 allocation and slippage as well as the 2020/21 allocation. Specifically, this resulted in a minimum investment in cancer programmes of £2.16m from 2019/20 and £3.21m from 2020/21 LTP Fair Shares funding:

LTP Fair Share Funding

Table 1: LTP Fair Shares funding, £000s

Description	2019/20	2020/21	2021/22	2022/23	2023/24	TOTAL
Mental Health						
Perinatal Mental Health	270					270
CYP Community & Crisis		85	3,814	5,888	9,688	19,475
Adult Crisis		1,667	1,773	2,373	3,091	8,904
- CRHTT	845					845
- Crisis alternatives and ambulance	637					637
New Integrated Models of Care	0	0	6,845	16,680	20,656	44,181
	1,752	1,752	12,432	24,941	33,435	74,312
Primary Medical and Community Services						
Primary Care			27,039	27,560	27,273	81,872
- Training Hubs	534	640				1,174
- Fellowships core offer	480	426				906
- Fellowships - Aspiring leaders	614	900				1,514
- PCNs	2,331	2,614				4,944
Ageing Well	0	1,659	3,868	11,270	18,944	35,740
	3,958	6,238	30,907	38,830	46,217	126,150
Cancer						
Cancer			3,924	3,757	3,756	11,436
- Rapid diagnostic centres	824					824
- Faster diagnostic pathways	674	1,439				2,113
- Personalised care allocations	421	1,188				1,609
- Cancer Allicance funding	242	583				825
	2,160	3,210	3,924	3,757	3,756	16,806

Programmes of work detailed in the LTP, specifically lung health checks (LHC) and Rapid Diagnostic Centres (RDC's) are funded from targeted funding, aligned with other cancer alliances nationally. In 2019 targeted funding supported the development of LHCs Tameside and Glossop, GM Cancer will be working with the national team on a programme of wider LHC work in 20/2021. Targeted funded RDC's will be established within 2 sites in GM in 20/2021 at Manchester Foundation Trust and Northern Care Alliance.

1.7 The GM Cancer Senior Management Team has undertaken an extensive review of the LTP submission with a view to determining the financial investment required to deliver all elements of the plan between 2020/21 and 2023/24. Total proposed funding requirements to deliver the LTP for Cancer is £46,052,000. A process of prioritisation and refining of proposals is currently being evaluated GM Cancer and Commissioning teams. This financial planning will continue to ensure a fully costed LTP plan is developed to indicate the required investment to 2023-24, provisional allocation required would be:

2020-21	2021-22	2022-23	2023-24
11,324	15,208	11,804	6,556

1.8 This process of financial evaluation has highlight potential funding deficits between funding allocated by the system in GM to deliver the LTP and expectation of full delivery of the LTP by NHSE. Discussions are ongoing with GMH&SCP with regards to future funding for GM Cancer and investment in Cancer Services in GM. Discussions are to take place at both Provider Federation Board and Joint Commissioning Board regarding the funding for the delivery of the LTP for Cancer and to support funding for the GM Cancer core team. Current identified funding sources for 20/2021:

Funding Source	Value £000
2019-20 Fair Share	2,160
2020-21 Fair Share	3,210
2020-21 Slippage against £10m GM Cancer TF	980
Total	**6,350**

1.9 GM Cancer has initiated a process of identifying and prioritising programmes of work for fair share funding and slippage against to TF 1 projects. For slippage funding this has been prioritised as:

- Completing 'priority 1' / 'TF1' projects
- Prehab for Cancer - programme funding finishes 09/2020 – extend to 31/3/2021 in line with other phase1 projects
- Stratified FU (for full roll as stipulated by NHSE and in line with other alliances and as per planning guidance – breast, prostate, colorectal)
- CURE – full GM roll out therefore additional localities in 2020-21
- Operational performance delivery of CWT standards-backlog clearance plan and sustainability/ recovery programmes
- Core team funding support delivery

For LTP Fair Share funding and targeted funding, programmes of work which would ensure the most significant impact on 1 year and 5 year survival, cancer outcomes and operational performance these would be:

- RDCs (Targeted funding - £15m 2020-21/23-24; LTP funding 2019-20)
- LHC (Targeted funding - £6m)

- Best timed pathways (BTP): Oesophago-Gastric (OG), Head & Neck (H&N), hepatoPancreatoBiliary (HPB) & Gynaecology Best Timed Pathways
- Stratified FU and personalised care
- Operational performance delivery of CWT standards

Further breakdown of these costs are proposed below:

Proposal	Value 2020-21 £000
Prehab for Cancer – extend from Sept 2020 – Mar 2021	£373
CURE (full roll out in all localities)	£409
Operational Performance:	
Additional backlog clearance activity	£697
Step change in diagnostic waiting times	£1,745
Step change in time to first Outpatient appointment	£491
Stratified follow up	£214
OG BTP	£666
H&N, HPB & Gynaecology BTP	£825
GM Cancer Alliance core team	£375
Rapid Diagnostic Centres	£800
Total	**£6,595**

1.10 **Recommendations for the board:**

- Approval of the paper outlining financial plans/ areas of prioritisation for 2020/21 for GM Cancer to deliver the Cancer programme in GM aligned with the LTP for Cancer.

Paper 4

Communications Paper

Title of paper:	Communications Paper
Purpose of the paper:	Information at national and local level for the attention of the Cancer Board
Author of paper and contact details	**Name: Anna Perkins** **Title: Communications and Engagement Lead** **Email: anna.perkins@christie.nhs.uk**

1. National Updates

National Cancer Alliance Quarterly Update Report
The National Cancer Alliance team has published its latest quarterly report, covering achievements between October 2019 and January 2020.
There are two work programmes from Greater Manchester Cancer featuring within the report following close contact with the national communications team:

- **Prehab4Cancer:** Highlighting the extensive national media coverage over the Christmas period and featuring an image of GM patient David and his trainer Kirsty Rowlinson-Groves from the prehab4cancer team (**page 5)**
- **GatewayC:** Highlighting the free cancer education tool developed in Greater Manchester across the primary care workforce in NHS England **(page 10)**

You can view the full report here.

Cancer Updates to the CQC
Cally Palmer has written to Cancer Alliances outlining the changes that CQC have made to their regulatory approach to better reflect national and local priorities for cancer services. CQC have requested that each Cancer Alliance share a nominated contact who is able to speak to CQC twice per year as part of their stakeholder engagement activity. This activity is part of CQC's monitoring process and the intelligence gathered through conversations with Cancer Alliances will help to inform decisions on when to inspect trust services and where to focus during on-site inspections. Greater Manchester Cancer's CQC Lead is **Susi Penney**.

We expect CQC-Alliance discussions to include the following questions:

- Are the right professionals from the Trust engaged in the right meetings, discussions and development and delivery of the Cancer Alliance plans?
- Is the Trust meeting Alliance timelines?
- Is the Trust putting in place the right changes and improvements to contribute to joint working across local priorities?

Cancer Alliance Innovation Lead
Each Cancer Alliance has been contacted provide a nominated Innovation Lead contact for any information or requests going forward. Greater Manchester Cancer's Innovation Lead is Dave Shackley.

National Cancer Alliance Conference – 28 April 2020
The first National Cancer Alliance Conference will take place on 28 April 2020 at Kings Place, London. The Greater Manchester Cancer team have supported this work, providing evaluation information from our conference and facilitating visits from the National Team to our conference in 2019 – the feedback regarding which was excellent. Several members of the team will be attending the National Conference to represent GM Cancer.

GM Cancer shortlisted in BMJ Awards – 22 April 2020
Greater Manchester Cancer has been shortlisted in the Cancer Care category for The BMJ Awards 2020 for its work in Transforming Cancer Services.

The team will attend a judging panel on Wednesday 22 April 2020 before finding out if it is successful at the awards ceremony.
Along with other shortlisted teams, GM Cancer will be featured in an article appearing both in print and online on www.thebmj.com.

2. Regional Activity

Greater Manchester Cancer Annual Report and Research Report 2019
The Greater Manchester Cancer team are about to publish their Annual Report for 2019. Additionally, for the first time this year, the team are also publishing an accompanying Research & Innovation Report, in collaboration with the Manchester Cancer Research Centre.
Both reports will be circulated to key stakeholders across the GM system and will also be published via the Greater Manchester Cancer website. Hard copies will be available on request and a number of copies will be available at the March Cancer Board meeting.

Greater Manchester Cancer on BBC News – World Cancer Day
Following the death of BBC Presenter Dianne Oxberry in 2019 from ovarian cancer, BBC North West Tonight ran a week's worth of short feature report about the disease in the first week of February.
GM Cancer Director Professor Dave Shackley was invited on to the BBC Sofa as part of a live broadcast on World Cancer Day, to discuss the disease and how this compares to other cancer types in terms of diagnosis, survival and research. Professor Shackley used the opportunity to remind viewers of symptoms to be alert to and to visit their GP if they had concerns.
Other pre-filmed interviews included Prof Gordon Jayson (The Christie NHS Foundation Trust) amongst other researchers and patients, with varying experiences of the disease.

3. Cancer in the Press

Prostate now the most common cancer in England
Prostate cancer became the most commonly diagnosed cancer in England in 2018, overtaking breast cancer for the first time. Public health officials have credited the rise in diagnoses to prominent figures like Stephen Fry and Bill Turnbull who have spoken publicly about their experiences.
BBC News: Prostate overtakes breast as 'most common cancer'

'Chemotherapy-free' treatment for lymphoma made available for NHS use in England
A new 'chemotherapy-free' combination treatment has been made available for some adults with a type of non-Hodgkin lymphoma.
The latest decision by the National Institute for Health and Care Excellence (NICE) means that lenalidomide (Revlimid) with rituximab will now be an option for some people with follicular lymphoma after initial treatment. Link to CRUK article containing more information.

'Electronic nose' could warn about higher risk of oesophageal cancer
The Guardian reported this month that researchers are developing a new way to diagnose Barrett's oesophagus (linked to oesophageal cancer). The 'electronic nose', which distinguishes between people with and without Barrett's oesophagus by detecting and analysing the molecules in their breath, is one of several less invasive tools being developed to detect Barrett's oesophagus, some of which are already in clinical trials.

Paper 5

Rapid Diagnostic Centres: The Greater Manchester Approach

Title of paper:	Rapid Diagnostic Centres: The Greater Manchester Approach
Purpose of the paper:	To update the Greater Manchester Cancer Board on progress to date with the implementation of Rapid Diagnostic Centres (RDC's) in Greater Manchester Cancer Alliance; 2019 – 2024
Summary outline of main points / highlights / issues	• To advise the Board on the progress made to date in developing the RDC plan for the region. • An update on the NHSE submission to secure funding.
Consulted	• GM Cancer Rapid Diagnostic Centre Programme Board • GM Cancer Senior Management Team • GM Cancer Commissioning Managers • Manchester University Foundation NHS Foundation Trust • Northern Care Alliance NHS Group
Authors of paper and contact details	**Names & Titles:** Sue Sykes, GM Cancer RDC Programme Lead **Email:**susansykes@nhs.net

1) Background and Context

The RDC model in Greater Manchester has evolved from the Multidisciplinary Diagnostic Centre (MDC) pilot, delivered 2017- 2019. The Greater Manchester Cancer Board in July 2019 agreed that the Northern Care Alliance NHS Group (NCA) and Manchester University NHS Foundation Trust (MFT) would on behalf of the GM cancer system lead the initial development of RDCs.

The MDC pilot, demonstrated that 90% of patients received a yes/no to cancer at their first attendance; far exceeding the national FDS standard. The RDC programme will build on the MDC concept, supporting earlier and faster cancer diagnosis through tailored pathways of clinically relevant tests using hot reporting and patient navigation. The RDC approach will be to reduce attendances, with the ambition of patients receiving a yes/no at 23 days. The platform will ensure eligible patients are appointed chronologically thus reducing inequity. Roll out of RDCs will consider geographical access as a primary factor.
The information gathered during 20220/2021 at NCA/MFT will provide the GM Cancer RDC Programme Board on behalf of the GM Cancer Board with a clearer understanding of how RDC implementation is progressed across the whole of GM (EC), to ensure full population coverage by 2024.

1) Key discussion points

Title: To advise the Board on the progress made to date in developing the RDC plan for Greater Manchester Cancer Alliance

The development and implementation of RDCs in GM is currently being planned as per NHS RDC guidance led by the GM Cancer RDC Programme Board, chaired by Professor Chris Harrison, which reports to the Greater Manchester Cancer Board. Steering groups at both NCA and MFT have been established, feeding into a GM RDC Programme Board which reports formally to the GM Cancer Board.

A phased approach is being taken to build on the existing MDC services at both organisations:

- Northern Care Alliance will deliver an RDC service at Salford Royal and Royal Oldham Hospitals. GPs from Salford, Oldham, Bury and Heywood Middleton & Rochdale CCGs can refer to all services.
- Manchester University NHS Foundation Trust will deliver an RDC service at Wythenshawe Hospital, Withington Community Hospital and North Manchester General Hospital. GPs from Manchester and Trafford CCGs can refer to these services.

From March 2020 onwards all sites will provide a non- specific symptoms pathway. In the first quarter of 2020/2021 MFT will develop RDC services for the Ovarian, Lung, and HPB and Haematology cancer pathways at agreed hospital sites. NCA will provide ovarian and upper gastro-intestinal pathways. This targets the pathways most challenging in GM currently. The GM ambition for RDCs is to develop a symptom based approach, to the diagnosis of cancer.

During 2020/2021, planning will also focus on developing access to RDC services for

patients from Wigan, Bolton, Stockport, Tameside and Glossop and potentially Eastern Cheshire CCGs. The RDC programme will ensure from April 2021 plans are in place to provide access to RDC non – specific pathways across all GM localities.

Over the following 4 years RDC principles will be applied to all other site specific cancer pathways in a phased approach, to ensure a system wide approach to the delivery of RDCs.

A stakeholder analysis and communication plan is being developed to include the whole system, which will be clinically and patient driven in line with the GM cancer ethos. A programme of stakeholder events is also being planned. Utilising the established patient and user involvement resources in GM, patient representatives will co-design all documentation for patients and have been part of designing the patient experience evaluation methods.

Title: Update on the NHSE submission to secure funding:

NHSE RDC 5 year planning guidance published in December 2019, recommends that by 2024 all Alliances will have achieved full population coverage (GM Cancer Alliance) for non-specific symptoms pathways, and RDC principles applied to every Two Week Wait site- specific pathway. The planning guidance has confirmed the proposed funding allocated to each Cancer Alliance from April 2020 to 2024:

Financial Year	**Allocation (£)**
2020/2021	2598,000
2021/2022	3813,000
2022/2023	3978,000
2023/2024	4932,000
Total	**15,321,324**

NHSE have been clear in their funding allocations that monies from year 5 can be brought forward if required to expedite the programme. However, any additional monies drawn early which are not utilised in this financial year will be lost. Therefore the Programme Board agreed to manage the outline plans to align with the funding allocated for the year, which will be reviewed in due course.

The GM Cancer RDC Programme Board has led on the completion of the 5 year delivery plan, including the demand and capacity modelling template. The delivery plan (see appendix 1 for further detail), which was submitted to NHSE on the 31st of January 2020, outlines detailed plans for 2020/2021 and high level plans for up to years 3 – 5 (2021 – 2024). Feedback from NHSE on the 12th of February 2020 was positive: '*Greater Manchester have provided a strong and clear plan. As the Alliance is an existing MDC there is confidence in their delivery and their approach. The plan shows good consideration of health inequalities with the Regional team recognising that they are implementing in the most deprived areas first.'*
The Programme Board have agreed the three amendments to the delivery plan in preparation for final submission on 28th of February 2020. NHSE will provide formal sign off of the GM Cancer RDC delivery plan in mid – late March 2020.

2) Next steps

With agreement from the Greater Manchester Cancer Board, the Greater Manchester Cancer RDC Programme Board will now work to embed the governance arrangements needed for the delivery and expansion of the RDC programme, with full scrutiny on operational plans and expenditure. It has been agreed that the site operational groups will formally report to this Board.

The full operational plan will be developed alongside the expected financial envelope for presentation at the next GM Cancer Board meeting.

3) Recommendation to Cancer Board

The Board is asked to acknowledge the submission to NHSE and agree for GM Cancer RDC Programme Board to undertake the operational evaluation and scrutiny of the initial plans and develop exception reporting and risk escalation for this.

4) Requests / support required of the Board

The Greater Manchester Cancer Board is asked to note the progress made to date and support the proposed way forward.

Refer to Paper 6, appendix 1 for the delivery plan (NHSE submission to secure funding)

Paper 6, Appendix 1.xlsx

Paper 6

GM Cancer led Transformation Projects Update

Title of paper:	GM Cancer led Transformation Projects Update
Purpose of the paper:	The purpose of the paper is to provide members of the GM Cancer Board with an update on progress and highlight risks associated with delivery of the GM Cancer led Transformation Funded projects.
Summary outline of main points / highlights / issues	• Good progress to date for each of the transformation projects is detailed • No high risks to escalate to GM Cancer board • Adherence to budget allocations documented
Consulted	• GM Cancer Programme Assurance Group
Author of paper and contact details	**Name:** Alison Armstrong **Title:** Programme Lead, Greater Manchester Cancer **Email:** alison.armstrong7@nhs.net

GM Cancer led Transformation Projects Update
March 2020

Project:	Accelerated Pathway: Lung
GM Cancer Leads:	Seamus Grundy – Clinical Lead Delwyn Wray – Project Manager

Summary of project

The GM Optimal Lung Cancer Pathway will address some of the poor outcomes of this highly prevalent disease and reduce the variation across the region, ensuring all patients receive the highest level of care, comparable with the top performing trusts. The Optimal Lung Pathway was developed by the Greater Manchester (GM) Lung Cancer Pathway Board to go above and beyond the national guidance set out in 2017. The aim of the Optimal Lung Pathway was to ensure all lung cancer patients in GM have a clear rapid diagnosis, whether or not it is lung cancer and any patient with lung cancer should be treated within 28 days of initial referral and upgrade to the pathway.

Progress and Roll Out Proposals

- The implementation and recruitment process for the Lung BTP is now approaching its conclusion, with 100% of Pathway Navigator roles recruited into post and only one CNS post vacant. Two specialist Christie posts are in the recruitment phase.
- The challenges to gather baseline data to support the creation of a project Dashboard within Tableau continue and have been escalated to the GMHSCP BI Lead and GM Cancer Programme Assurance Group.
- Work with Pathway Navigators already recruited into post has commenced in identifying and recording local information / data to support analysis and progress following the introduction of roles at individual provider level.
- Partnership and communication with NHS England (NHSE) has begun regarding the "Getting it Right First Time" (GIRFT) programme initiative designed to improve clinical quality and efficiency. NHSE are focusing across Greater Manchester on the Optimal Best Timed Pathway for Lung Cancer with provider trusts, this has included invites for GMC to attend and be included in all meetings.
- Since our last report a number of presentations regarding the Optimal Best Timed Pathway for Lung have been delivered at local and national forums.

Profiled Spend and Forecast

	Allocated Budget	2018-19 IAT	2019-20 FOT	2020-21 Total FOT	Total Forecast
GM Project: BTP Lung	1,258,000	10,000	307,292	771,400	1,088,692

Project:	Accelerated Pathways: Prostate
GM Cancer Leads:	Satish Maddineni – Clinical Lead Susan Todd – Project Manager

Summary of Project

Timely prostate cancer diagnosis and treatment continues to be a challenge nationally and across GM given the increasing numbers of referrals and the complexities of the pathways. The GM Urology Pathway Board has led the National Cancer Vanguard in agreeing a timely, accurate and evidence based best timed diagnostic pathway for prostate cancer that supports the NHS England 28 day faster diagnosis standard.
The BTiPP project aims to support all provider Trusts who have a urology prostate service for

new referrals within GM, to implement the new diagnostic pathway. In particular undertaking mpMRI prior to optimal prostate biopsy method. Working in conjunction with provider Trusts to establish and embed the NHSE best timed prostate pathway to faster diagnosis by day 28 for all new suspected prostate cancer referrals across GM. To give equal patient support and access to the pathway and specialist prostate cancer diagnosticians/clinicians, minimising patient travel and morbidity where possible.

Progress and Roll Out Proposals

Progress to date includes:

- Majority of TF workforce in post or imminent start date.
- 'Introduction to BTiPP' session delivered 31/1/20, further session planned May/June, well received. Some generic training for pathway navigators may be offered by GM Cancer also.
- Standardised mpMRI scan protocol agreed across GM. Bespoke 1 day 'GM Cancer Radiology mpMRI Masterclass' developed, for delivery 13/5/20 for GM Uro-Radiologists and MRI Lead Radiographers.
- Straight to test mpMRI scan to be offered pre-biopsy by all 7 GM Trusts by 1/4/2020. On track.
- To enable move towards optimal prostate biopsy method – transperineal route under local anaesthetic (LATP), across GM, the BTiPP project has funded varying items of capital equipment for the 7 Trusts. To be procured by 31/3/20.
- Data – First monthly report by Trusts being collated. Expected to be incomplete as requires pathway navigator to be in post to manually gather data as no central system collects all required.
- Draft patient information sheet is in use in Trusts, to go to Primary Care shortly. Draft patient experience survey is being piloted at SRFT.

Profiled Spend and Forecast

	Allocated Budget	2018-19 IAT	2019-20 FOT	2020-21 Total FOT	Total Forecast
GM Project: BTP Prostate	885,000	10,000	380,171	493,800	883,971

Project:	**Accelerated Pathways: Colorectal**
GM Cancer Leads:	David Smith – Clinical Lead Jonny Hirst – Project Manager

Summary of Project

Colorectal cancer is the fourth most common cancer and the cancer that takes the second highest numbers of lives every year in the UK. Greater Manchester is currently facing challenges with the delivery of the cancer waiting time standard for colorectal cancer, with 67.5% of patients receiving their treatment within 62 days for 2018/19. (National standard 85%). Furthermore, by 2020 the new Faster Diagnosis Standard (FDS) of confirmation of cancer diagnosis (or no cancer) by day 28 following a suspected cancer referral will be implemented.

This project aims to support Trusts to establish or improve upon straight to test (STT) for appropriate patients, with first clinic appointment within 7 days for those not appropriate for STT. This will reduce the time to a diagnosis and ultimately treatment. Additionally, the efficiencies the project will realise due to a reduction in the numbers of outpatient appointments required and a reduction in the number of DNAs for endoscopy is anticipated to more than balance the cost of the new service.

Progress and Roll Out Proposals

Processes are being put in place to audit primary care urgent referrals and regularly share the results of these audits with GP practices. Further engagement with GP practices will occur as required to support best practice in relation to urgent referrals.

The project is currently in the early implementation stage of the new STT pathway in 3 Trusts, with the other Trusts due to follow shortly. It was hoped that all Trusts would have launched their STT pathways by March 2020; however recruitment for the new CNS and Pathway Navigator roles in some Trusts has taken longer than anticipated. In some cases multiple rounds of recruitment has been needed.

Profiled Spend and Forecast

	Allocated Budget	2018-19 IAT	2019-20 FOT	2020-21 Total FOT	Total Forecast
GM Project: BTP Colorectal	989,000	10,000	246,500	728,000	984,500

Project:	**Prehab4Cancer**
GM Cancer Leads:	John Moore – Clinical Lead Zoe Merchant – Project Manager

Summary of Project

Prehab4Cancer is an evidence-based prehabilitation and rehabilitation programme which incorporates exercise, nutrition and wellbeing interventions to optimise people diagnosed with cancer prior to treatment (surgery, chemotherapy and/or radiotherapy) and to support enhanced recovery. Approximately 2000 people will benefit from participating in this programme over the next 2 years and it is the first prehab programme to be delivered at scale nationally.

The programme is designed to achieve improved clinical outcomes with increased survival rates and improved morbidity. It contributes to greater quality of life, empowering participants to live well with and beyond cancer. Physiological status, PROMs and PREMs are recorded at regular intervals via leisure facilities database system Refer-all. There is provision within this project to develop a digital platform in conjunction with HInM to further support physiological and QOL data collection, facilitate clinical monitoring of patients and provide enriched participation to the programme. This will include participants using wearable devices (heart rate monitors).

Progress and Roll Out Proposals

- This programme has received over 850 referrals within the first 9 months with over 650 people having now participated in the programme.
- The service specification has a high degree of acceptability from patients referred with an 83% initial uptake rate from referral and a 97% uptake rate from first appointment. 96% of patients referred are contacted within 2 working days of referral receipt, with 100% of patients accessing the programme at a leisure facility local to their residential postcode.
- Patient experience continues to be consistently positive, with participants motivated to return to the programme following surgery.

Phase 2 Progress:

- Roll-out to appropriate head & neck surgical patients by April 2020 is envisaged. For non-surgical cohorts (Lung and Head and Neck) ethical approval and research mechanisms are required to be in place, with the aim for them to be included by Q2 of 2020.
- An alternative ‘specialist’ offer, to be delivered by AHPs and fitness instructors in clinical

settings, aimed at eligible patients identified as high risk, with complex co-morbidities, not able to safely engage in the programme in its current format, is under development in collaboration with Manchester Institute for Health and Performance and NHS secondary providers. This will commence in Q2 2020.

- The Prehab4Cancer website (www.Prehab4Cancer.com) is currently in production and due to be delivered at the end of March 2020. Comments will be sought from all pathway clinical leads and approval from cancer board before this is launched publically.
- Great progress has been made with CCG's with approval given for the Prehab4Cancer dataset to be included in existing data sharing agreements, supported by the GMHSCP BI team and aggregated via the partnership's software solution (Tableau) to facilitate useful and robust evaluation of high level patient clinical outcomes of programme participants. This will support demonstration of value for money of programme delivery.
- Drafting of the business case to support programme sustainability will begin in March 2020 in discussion with key opinion formers.

Profiled Spend and Forecast

	Allocated Budget	2018-19 IAT	2019-20 FOT	2020-21 Total FOT	Total Forecast
GM Project: Prehab4Cancer	1,168,000	36,000	644,017	478,328	1,158,345

Project:	Recovery Package
GM Cancer Leads:	Wendy Makin – Clinical Lead Suzanne Lilley – Project Manager

Summary of Project

The full implementation of the Recovery Package Personalised Care Interventions is one of the key objectives in the GM Cancer Plan. Work is underway to ensure that all appropriate patients diagnosed with cancer in GM receive a Holistic Needs Assessment both before and after treatment. 7800 HNAs were recorded across the region in 2018. This is suspected to be an under estimate as not all Trust IT systems were able to capture this activity in the first half of 2018. We will also ensure that treatment summaries are provided to patients, and copied to their GP, at the end of each treatment modality. We are working to develop a sustainable Health and Wellbeing offer for all patients approaching the end of treatment. Much of this work is being led by Macmillan-funded Recovery Package Project Managers in the acute Trusts, and is co-ordinated at GM Cancer level.

Progress and Roll Out Proposals

- New project manager overseeing the project
- All cancer care coordinators are in post across all sites
- Outcomes have been finalised and first data collection will be complete in quarter 2
- Positive feedback has been received from cancer CNS
- The senior care coordinator post was working across two sites over two different models however is now focusing on one site only

Profiled Spend and Forecast

	Allocated Budget	2018-19 IAT	2019-20 FOT	2020-21 Total FOT	Total Forecast
GM Project: Living With & Beyond Cancer	500,000	0	166,665	303,968	470,633

Project:	CURE
GM Cancer Leads:	Dr Matthew Evison – Clinical Lead Freya Howle – Project Manager

Summary of Project

The CURE project is a comprehensive secondary care treatment programme for tobacco addiction. At its heart is systematically identifying all active smokers admitted to secondary care and immediately offering nicotine replacement therapy and other medications, as well as specialist support, for the duration of the admission and after discharge.

Progress and Roll Out Proposals

- All posts across GM are out to recruitment – there are a total of 18 new posts therefore the timings of adverts have been staggered to encourage an equal number of candidates across all sites.
- Updates have been made to patient recording systems in Bury, Rochdale, Salford and Stockport and are all in testing phase before formal use. A trust wide freeze on updates has caused a delay in Wigan. The importance of the ability to record data was escalated at the Tameside & Glossop Task & Finish Group.
- ELearning modules being progressed through individual Trusts L&D governance processes – currently available on CURE website to complete
- Dr Evison attended Grand Rounds at Stockport, Salford and Tameside & Glossop
- Communications plans agreed at all Trusts with posters, screensavers, blogs, trust wide emails and stalls being used currently.
- Plans for formal launch across NCA sites (main site to be Salford) to link with National No

Smoking Day.
- CCG pharmacotherapy spend impact paper presented to each locality Task & Finish Group with the action for the Tobacco Commissioners to share with their Medicines Optimisation Teams.
- The Delphi Study and a baseline data collection audit (which will inform the readiness across GM for a standardised evaluation framework) has been completed across the 7 GM sites, Liverpool NHS Foundation Trust and 2 London sites.
- PHE Behavioural Insights evaluation into how the CURE model was implemented in Wythenshawe Hospital has been agreed
- Risks previously flagged to the GM CURE Steering Group have been addressed and we are making progress with implementation in all localities so no high risks to escalate
- A significant number of visits have been made and presentations delivered by the CURE team who have been shortlisted for a HSJ award

Profiled Spend and Forecast

	Allocated Budget	2018-19 IAT	2019-20 FOT	2020-21 Total FOT	Total Forecast
GM Project: CURE	1,866,000	27,000	463,975	1,077,019	1,567,994

Project:	**Transforming Aftercare**
GM Cancer Leads:	Mohammed Absar – Clinical Lead Astrid Greenberry - Project Manager

Summary of Project

This project enables the identification of patients who are suitable for supported self-management, reducing the demand for routine follow up, and releasing capacity to address the expected increase in patient numbers.

Initially the project is rolling out the personalised stratified follow-up pathway that was put in place at Pennine Acute Hospitals NHS Trust and Manchester University NHS Foundation Trust (Nightingale Centre) through the Macmillan Cancer Improvement Partnership Programme to the remaining breast services in Greater Manchester
In addition testing and evaluating a personalised stratified follow-up pathway for colorectal cancer.

Progress and Roll Out Proposals

- Breast Personalised Stratified Follow-up
  Bolton – Go Live date for pathway 1/1/20. Cancer Care Coordinator in post from 9/3/20.
  Stockport – Project support agreed to enable MFT to provide Stockport patients with PSFU.
  Tameside and Glossop – End of treatment appointments starting in Feb 20.
  Wigan, Wrightington and Leigh – Pathway went live on 1/1/20. Cancer Care Coordinator in post
  from 2/3/20.
- Colorectal Personalised Stratified Follow-up
  Stockport - Cancer Care Coordinator in post from 9/12/19.
  Salford – Evaluation of service March – Sept 20.
- The funding Agreement for InfoFlex, the IT solution has been drawn up and is with Trusts for sign off.

Profiled Spend and Forecast

	Allocated Budget	2018-19 IAT	2019-20 FOT	2020-21 Total FOT	Total Forecast
GM Project: Stratified Follow Up	734,000	8,000	212,663	513,337	733,999

Project:	**CAN-Guide (Supported Decision Making around Palliative Chemotherapy)**
GM Cancer Leads:	Janelle Yorke – Clinical Lead Grant Punnett – Project Manager

Summary of Project

Following a successful small Greater Manchester pilot of an enhanced-decision making package called the 'Goals of Care Initiative (GOCI)', we are now setting up an innovatively designed research study to formally evaluate the GOCI tool when used widely in a clinical setting. 800 patients will be studied over 2 years (in 7 types of cancer) from May 2019 with the hope that, if successful, evidence will be developed which supports broader roll out in GM and beyond as part of a standardised approach. The overall aim of the Can-GUIDE programme is to improve the way information is presented to patients with progressing cancer about the benefits and risks of further systemic treatments (chemotherapy and biological agents), and empower patients to fully engage in shared-decision making.

Progress and Roll Out Proposals

- Data collection within the six disease groups to establish a baseline of patient involvement in Shared Decision Making prior to the first wave of implementation of the GOCI is continuing.
- The first two disease groups will be implementing GOCI at the end of February (lung and sarcoma). Content of the GOCI booklet has been completed and we are awaiting the first prints prior to distributing to the relevant disease group support teams. The GOCI website has been designed and final interactive resources are being incorporated prior to the first disease groups implementing GOCI. Links to the website are available to patients within the booklet.
- Conversational frameworks for each disease group are in the process of being developed in collaboration with members from of the clinical teams and NHS England and will form part of the GOCI clinician training. Training for the first two disease groups has been developed and will be delivered within team meetings at the end of February/beginning of March.
- The other four disease groups (colorectal, breast, gynaecology and renal) will be implementing the GOCI within their clinics at a later date. Two groups will implement in August 2020 with the final two groups implementing in early 2021. Data will continue to be collected from all 6 disease groups to ensure we have sufficient baseline data and data following GOCI implementation. Interviews with stakeholders will also take place over the next year to establish usability and acceptability as well as barriers and facilitators to wider GOCI roll out.

Profiled Spend and Forecast

	Allocated Budget	2018-19 IAT	2019-20 FOT	2020-21 Total FOT	Total Forecast
GM Project: Goals of Care	564,000	100,000	284,839	179,161	564,000

Project:	**Cancer Education**
GM Cancer Leads:	Dr Catherine Heaven, Programme Director for Cancer Education Rachel Hickson – Project Manager

Summary of Project
The Cancer Education project will work with all stakeholders across the GMHSCP (in health & social, voluntary, charitable and community) to create opportunities for equal access to education for cancer care givers across GM & EC. The aim is a collaborative system wide approach to workforce development; upskilling the workforce, resulting in better patient experiences across the region, as a trailblazer for the NHS nationally. This two year transformational education programme has three core elements: - Creation of an education transformation team - Dedicated cancer education leadership - Ongoing development of GatewayC, educational events and other innovative methods of delivering education across GM & EC.
Progress and Roll Out Proposals
• Delivered the Greater Manchester Cancer Conference in November 2019, extremely positive feedback. Planning for GMCC 2021 has begun. Planning continues for Genomics Conference 29th April, tickets released. • First date for Cancer Navigator & MDT Coordinator training set for May 2020, planning continues. • 2/10 commissioned Advanced Communication Skills courses have taken place. • Psychological Level 2 planning continues. Main obstacle to uptake will be the pre-requisite for Trusts to have Level 3 & 4 supervision in place in order for their staff to be allocated a funded place. • Lymphedema skin care management video; filming took place, edits received, graphics and VO to be added. • Initial meetings have taken place with various Social Care/Palliative & EOL Care/Strategic Clinical Network contacts to discuss collaboration. • Cancer Managers Engagement day planned for 13th March in preparation for change re CWT

Profiled Spend and Forecast

	Allocated Budget	2018-19 IAT	2019-20 FOT	2020-21 Total FOT	Total Forecast
GM Project: Education	610,000	22,000	117,379	470,621	610,000

Project:	**Cancer Intelligence Service**
GM Cancer Leads:	Graham Beales – Head of BI GMHSCP

Summary of Project

This project seeks to deliver intelligence and insight into the GM Cancer delivery team and beyond into the GMHSCP / GMEC system. By aligning to the GMHSCP BI team since October 2019, there are many opportunities that can be realised both in terms of technology and expertise.

The project seeks to build towards being a national exemplar in demonstrating actionable insight and world class business intelligence. Key milestones will be.

- Set solid data foundations - single sources for performance and insight reporting, ensuring alignment with national and local expectations in terms of information delivery.
- Robust data management of patient level data, ensuring the flows are suitable for meeting the requirements of the region.
- Develop self-service provider / commissioner performance reporting via GM Tableau
- Develop GM Cancer board report and pathway board reports utilising GMHSCP KPI database approach.
- Develop logic for patient level data to deliver requirements against the best time pathways, outside of national reporting logic.
- Collaborate with provider and commissioner BI teams to coproduce reports that are understood against a wide cross section of GMHSCP/ GMEC organisations breeding confidence in GM Cancer Intelligence reporting.
- Continuation of Ad-Hoc requests to support GM Cancer Team in day to day operations.

Beyond this point the team will work towards a cancer application of the GM Health and Care Intelligence strategy in terms of working towards delivering risk stratification, forecasting and actionable insight alongside strong performance and business intelligence reporting.

Progress and Roll Out Proposals

- Initial Board Style report presented to cancer board, with agreement to review the necessary metrics with a SPRINT planned for March.
- Multiple data sources have been automated from publicly available sources, to deliver single sources of data from nationally published metrics at various available aggregations.
- Provider and Commissioner views of national published data available via GM Tableau
- Key CCG metrics report produced from multiple data sources available via GM Tableau
- New team structure agreed with interviews pending for 8a Senior analyst, 7 Data Manager and 5 BI analyst.
- Provider collaboration meeting was successful with new local data flows being worked on to support daily PTL feed and better views of diagnostics to support system working.
- Commissioning leads aware of the move to GM Tableau and the change in team management following presentation at commissioner meeting.
- New national metrics feed in place, awaiting population by national team.
- IG clarity has been reached with agreement as to next steps, with DARS application amendments agreed to rationalise two existing agreements into one.
- Facts and Dimensions work has begun with support from temporary contract resource within GMHSCP infrastructure for patient level data normalisation.

Profiled Spend and Forecast

	Allocated Budget	2018-19 IAT	2019-20 FOT	2020-21 Total FOT	Total Forecast
GM Project: Cancer Intelligence	387,000	140,000	168,756	160,908	469,664

Paper 7

GatewayC Update – March 2020

Title of paper:	GatewayC Update: March 2020
Purpose of the paper:	Update the Cancer Board on the performance of GatewayC, the online cancer education platform
Summary outline of main points / highlights / issues	This paper will consider the following metrics: • Volume of registrations of healthcare professionals in Greater Manchester • Measure of performance • Outcome and performance
Consulted	An update has been previously requested by the Cancer Board.
Author of paper and contact details	**Name: Anna Perkins** **Title: GatewayC Programme Lead - Marketing** **Email: Anna.Perkins@Christie.nhs.uk**

1. Background to GatewayC

GatewayC is an online education platform for primary care, originally devised as one of the programmes of the Greater Manchester Cancer Vanguard.

The platform offers a range of online cancer courses, designed to support primary care professionals in the recognition of red flag symptoms and in making clinically appropriate suspected cancer referrals, in line with NICE NG12 guidelines. This supports the early diagnosis targets in the NHS Long Term Plan and also aims to improve the experience of patients, both through effective communications throughout the pathway and, where possible, more favourable outcomes.

The tool is accredited by the Royal College of General Practitioners and has the support of both Macmillan Cancer Support and Cancer Research UK. It is undergoing NICE accreditation. The GatewayC team are also working with a number of other major cancer charities including Bowel Cancer UK, Prostate Cancer UK, Breast Cancer Care and Leukaemia Care.

2. History of the Tool

Vanguard Programme and Northern Rollout
Following a successful pilot in Greater Manchester (results published November 2017), Health Education England funded the continuation of the tool, both in developing an additional suite of educational courses and also in providing access to the seven northern cancer alliances.

During this time, the platform has continued to develop and grow, both in the number of educational resources it offers and in terms of the number of primary healthcare professionals using the tool from across England.

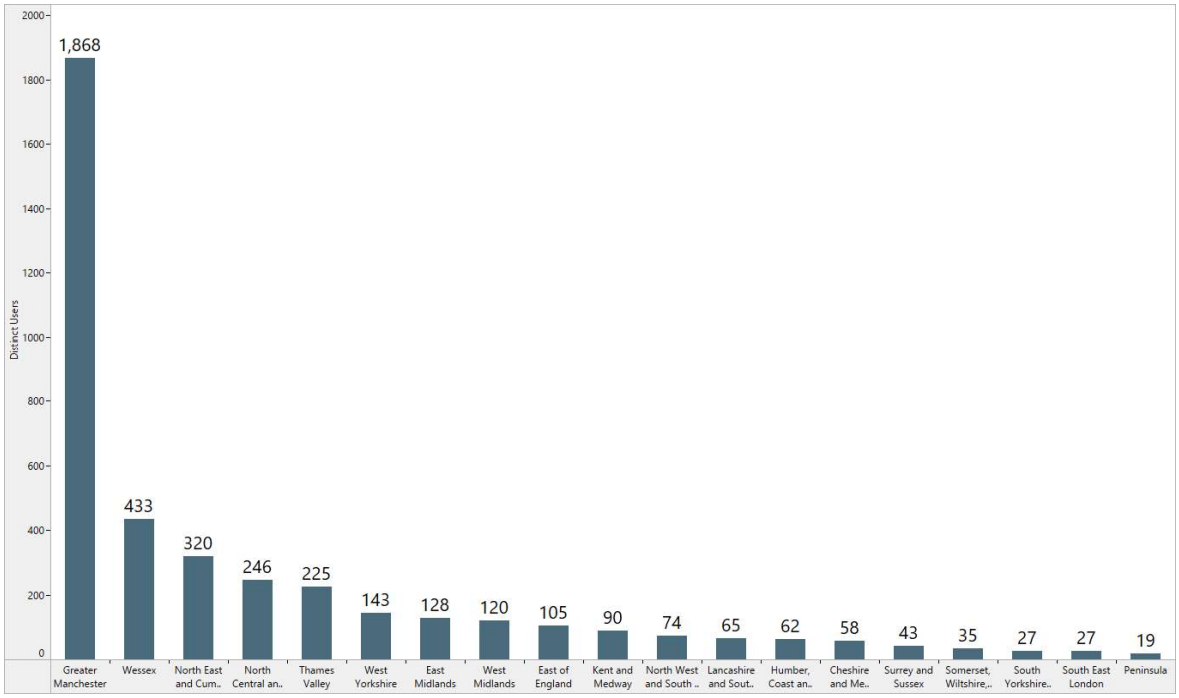
National Rollout (NHS England)
In August 2019, HEE agreed to fund the tool to roll-out nationally, to all primary care professionals across NHS England. In addition to this, it also funded the continued development of further educational courses to support the primary care workforce.

3. Greater Manchester Performance

Greater Manchester has a significantly higher number of users than the rest of NHS England. As previously mentioned, this can be in part associated with the length of time GatewayC has been available within Greater Manchester. The pilot programme across Greater Manchester also supported the embedding of the tool across the system through close working with the Cancer Alliance, clinical leads, primary care leads, CCG leads and the Cancer Research UK Facilitator Team.

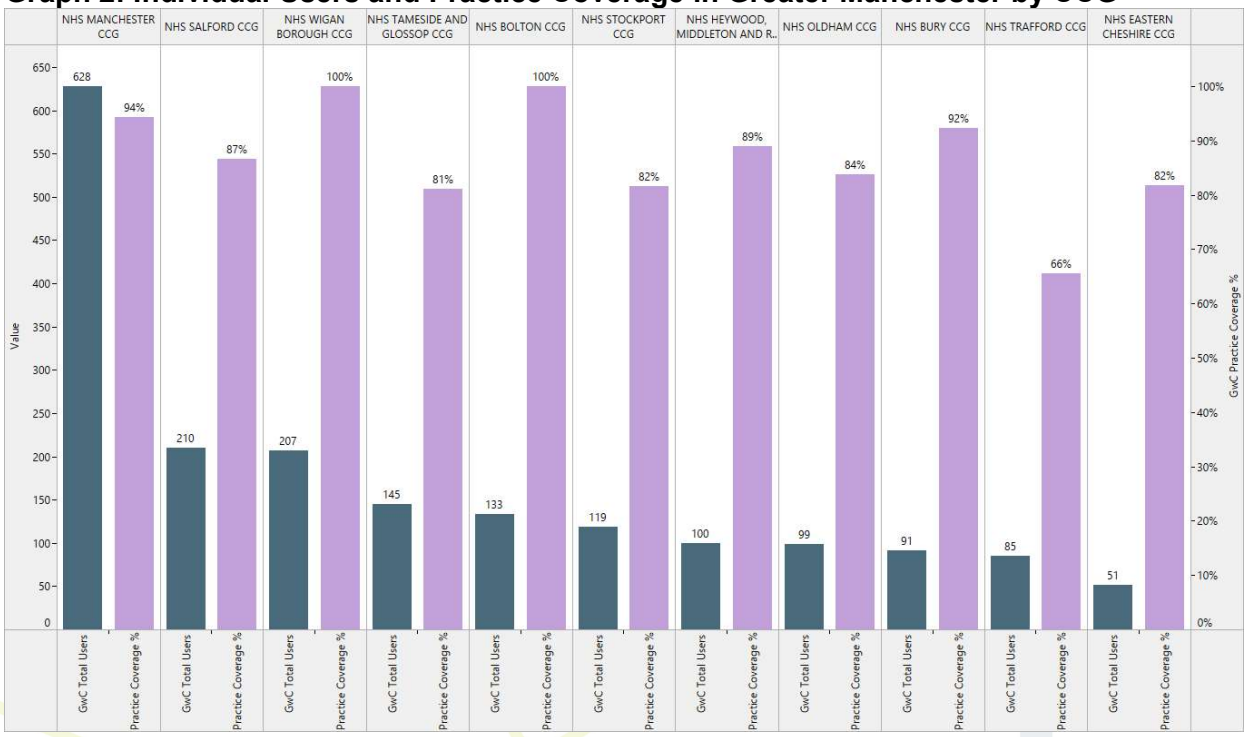
The GatewayC team is actively approaching different cancer alliances to promote the tool with varying uptake from across the system, as shown in Graph 1 (overleaf).

Graph 1: Number of GatewayC users by Cancer Alliance – March 2020



The team is now working closely with other Alliances and CCGs, major cancer charities, Health Education England and NHS England, in addition to sharing best practice from Greater Manchester to improve uptake across England.

Graph 2: Individual Users and Practice Coverage in Greater Manchester by CCG



Graph 2 demonstrates the number of unique user by CCG across Manchester.

The three CCGs with the highest number of individual users are:

1. Manchester CCG (628)
2. Salford CCG (210)
3. Wigan CCG (207)

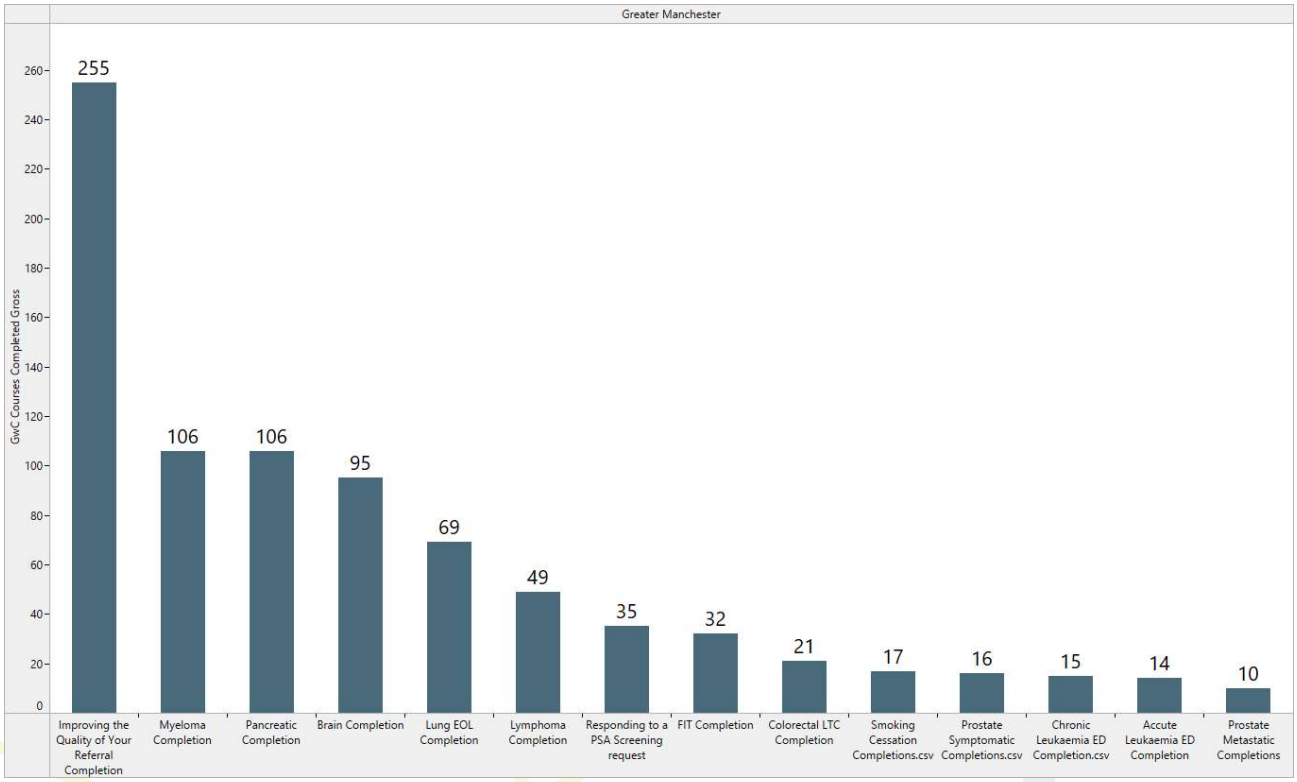
These can be largely attributed to the proactive inclusion of GatewayC modules into primary care standards in these areas, with Manchester CCG also incentivising its GP workforce to complete the 'Improving the quality of your referral' course from February to April 2019 through payment made to practices upon completion.

Practice Coverage: (at least one GatewayC user per GP practice)

1. Wigan and Bolton CCGs – 100%
2. Manchester CCG – 94%

Practice coverage statistics are extremely positive, with Wigan and Bolton CCGs both achieving 100% practice coverage, closely followed by Manchester CCG. The lowest level of practice coverage is in Trafford CCG, which is still at a health figure of 66%. Practice coverage is significant as we know from feedback in GatewayC post-surveys that many primary care professionals share their learnings with other colleagues in their practice as part of their 'action plan', thus extending the benefit of the education.

Graph 3: Course data



Graph 3 demonstrates that the most popular course to date has been the 'Improving the quality of your referral' course. This is a course that has been incentivised within Manchester CCG but has also been put into standards in some other CCGs.

This particular course considers clinically appropriate referrals (ensuring in line with NICE NG12 guidance), good quality referrals (ensuring patient information such as contact details, comorbidities or frailty are included to allow the patient to be sent straight to test, for example) and effective communication with patients to improve their experience and reduce DNA rates.

Course feedback was positive; the pre-course confidence assessments expressed a desire from many GPs to improve their referrals, to keep up to date with the latest guidance and to avoid missing opportunities for an early diagnosis.

Post-course feedback examples:

> **"This was excellent and really made me think-particularly about how I communicate at time of 2 week rule referral and how I safety net."**
>
> **"Useful to reflect on what I do even as a fairly experienced clinician."**
>
> **"Helps to fine tune what we do. Also prompts about the minor things we may not always consider could cause a problem i.e. capacity or mobility"**

The high usage of GatewayC as an education tool in Greater Manchester in addition to the high uptake of this particular course correlates to latest figures from the NCPES Survey. These figures suggest Greater Manchester GPs are now more prompt at referring patients for suspected cancer than anywhere else in England, with 79.8% of FM patients seeing a GP one or two times before a cancer referral, as opposed to the England average of 77.3%.

3. Next Steps

Development
New courses continue to be developed to add to the current suite. Courses currently in development include breast cancer recurrence, ovarian cancer, oesophageal cancer, supporting your patient and managing the physical effects of cancer treatment, with more to follow.

In addition to the standard courses, new light-bite courses entitled "Cancer Conversations" are currently in development. These 10-15 minute, documentary-style videos touch on topics that primary care do not need to know *everything* about, but some knowledge would nonetheless benefit their clinical practice, including topics such as proton beam therapy, home genetic testing kits and clinical trials.

Roll-out
The GatewayC team continues to roll out the tool across NHS England, through working with Cancer Alliance teams, CCGs, major cancer charities including Cancer Research UK and Macmillan Cancer Support, through Health Education England and the NHS England team. This is also supported by face to face events, conferences and digital marketing to reach a

wider audience. We continue to monitor progress in this area and develop clear reporting metrics to demonstrate performance in these areas.
We are also currently piloting the tool for use in Wales, with Health Education and Improvement Wales (HEIW) interested in using the tool for their primary care staff. We expect to progress this later this year and continue to pursue other opportunities to extend the reach of GatewayC.

Sustainability
In addition to rolling out GatewayC across NHS England and exploring other geographical opportunities, GatewayC is also working closely with Health Education England to consider the long-term sustainability of the model. This includes considering how the platform may integrate with the current e-Learning for Health platform used for other types of mandatory training across the healthcare workforce. We will provide an update on this in due course.

Paper 8

Quality Surveillance Programme (Cancer) 2018/2019

Context

The NHSE QST requires an annual self-declaration of the compliance of cancer services within provider organisations via the Quality Surveillance Information Service (QSIS) system. This process provides assurance to commissioners that the services in place are compliant with a set of national standards. This process replaced the national peer review programme several years ago (2014/15) and was built on its robust framework to develop an integrated framework for quality assurance with particular emphasis on patient safety, patient experience, clinical effectiveness and outcomes. This process is called the Quality Surveillance Programme (QSP).

The Quality Surveillance Programme (QSP) aims to improve care for people affected by cancer by:

- Ensuring services are as safe as possible
- Improving the quality and effectiveness of care
- Improving the patient and carer experience
- Undertaking independent, fair reviews of services
- Providing development and learning for all involved
- Encouraging the dissemination of good practice

The intended outcome of the QSP annual assessment of cancer services is to ensure:

- Confirmation of the quality of cancer services provided by an organisation.
- Prompt identification of major shortcomings or risks to the quality of cancer services so that timely action can be taken.
- Timely information for commissioners.
- Robust action plans for areas of non-compliance.
- Reliable, validated information that is available to stakeholders.
- System support for non-compliant services.

This paper summarises the 2018/2019 QST finding together with recommendations for areas of future work in collaboration with both CCG's and providers.

Local Skin Service:

SRFT – Enhanced surveillance (Commissioner and Provider)

- Issue of increased capacity as a result of demand has been picked up at scheduled care dashboard

Bolton – Enhanced surveillance (Provider)

- Provider action due to a lack of consultant dermatologists. Issue is on the trusts' risk register within speciality and there are ongoing concerns around the sustainability of the service. Regular locum consultants are being utilised. The CNS has reported no 3rd consultant in post currently. Clinics run weekly but the MDT runs fortnightly. This is because this maximises clinical capacity at minimal risk.

Tameside – Enhanced surveillance (Provider)

- Provider to develop action plan to facilitate weekly MDT's

WWL – Enhanced surveillance (Provider)

- No weekly MDT. Any urgent cases are discussed with the LMDT lead and an interim decision made pending planned LMDT discussion. LMDT bi-weekly.

MFT (WTWA) – Enhanced surveillance (Provider)

- CNS confirmation of action – bid with Macmillan for second post.

Local Lung Service

PAHT (NMCO) – Enhanced surveillance (Provider)

- Monitor development of draft business case for additional staffing of the MDT and impact for achieving NOLCP following appointment of navigators in May.

Stockport – Enhanced surveillance (Provider)

- Diagnostic only service, no surgery provision. The self-assessment reflects the service available. There is an expectation that the provider will monitor attendance of key personnel at MDT – previous issues with palliative care consultant attendance but new post now in place so should be resolved.

WWL – Enhanced surveillance (Provider)

- Specialist palliative care nurse unable to attend MDT. Team needs to monitor palliative care support to these patients.

Tameside – Enhanced surveillance (Provider)

- SDIP required – sectorised model under consideration for palliative care compliance.

SRFT – Enhanced surveillance (Commissioner and provider)

- LHC's launched. Increased demand for 62-day appointments and diagnostic tests including CT guided biopsy. Risk this will lead to longer diagnostic pathways due to constraints around CT guided biopsy. SRFT/CCG monitoring the impact of LHC's.

Bolton – Routine surveillance

- Lack of timely capacity/access to PET services continues to be of concern, although this is recognised to be an external service out of local control to recover/influence. This leads to a negative impact on pathway performance for this tumour site. This has been escalated to GM cancer.

MFT (MRI) – Enhanced surveillance (Provider)

- Issues with palliative care cover for LMDT

MFT (WTWA) – Routine Surveillance

Local Upper GI Service

Bolton – Routine surveillance

- Cover arrangements for the clinical lead need to be put in place. Ongoing issue of job planning arrangements need to be resolved to address this.

PAHT (Oldham) – Enhanced surveillance (Provider)

- PAHT to ensure palliative care representation at MDT.
- PAHT to work with Christie to ensure clinical oncology cover as required.

Stockport – Routine surveillance
WWL – Routine surveillance

Brain/CNS Service
SRFT – Routine surveillance
Christie - Routine surveillance

Local Head and Neck Service
SRFT – Routine surveillance
Bolton – Routine surveillance
Tameside – Routine surveillance
PAHT (NMCO) – Routine surveillance
Stockport – Routine surveillance
WWL – Routine surveillance
MFT (MRI – Routine surveillance
MFT (WTWA) – Routine surveillance

Local Gynaecology Service
Bolton – Routine surveillance

- Recruitment of the posts remain a high priority for the trust. The criteria for cancer staffing clinical indicators is met, however, this statement is reflective of the trusts current position and not necessarily associated with QSIS. There is a lead clinician and a deputy but the information relating to staffing levels is for the trust in general.

SRFT – Routine surveillance
Stockport – Routine surveillance
Tameside – Routine surveillance
WWL – Routine surveillance
PAHT (Oldham) – Routine surveillance
MFT (WTWA) – Routine surveillance

Local Breast Services
Bolton – Routine surveillance
Tameside – Routine surveillance
PAHT (Oldham) – Enhanced surveillance (Provider and commissioner)

- Monitor progress regarding possible changes as to how patient information held by the CNS team around patient interactions/telephone support is collected/stored. Monitor outcome of Theme 3 (ISC).

Stockport – service now provided by MFT (WTWA)
WWL – Routine surveillance
MFT (WTWA) – Enhanced surveillance (Provider action)

- Oncology cover to be solved between MFT and Christie.

Local Urology Services
Bolton – Enhanced surveillance (Provider and commissioner)

- Concerns around increased workload. Evidence of significant redistribution of the traditional medical models of service delivery to more nurse-led care. Includes treatment reviews in the oncology clinics and telephone clinics in addition to other additional nurse-led clinic requirement to release consultant capacity.
- This is in spite of no increased uro-oncology nursing establishment and therefore concerns relating to the sustainability of the service. The lead cancer nurse for the trust has been working with Macmillan to address this issue. An expression of interest to Macmillan for a WTE Band 7 CNS is likely to get funding – awaiting substantive funding to be agreed. Business case with trust.

PAHT (Oldham) – Enhanced surveillance (Provider and commissioner)

- Ongoing issues with oncology provision. Ongoing concerns around 62-day performance reported through PAHT. Clinical and Medical Oncology attendance at MDT poor, this is part of a wider issue with attendance at MDTs by Clinical and Medical Oncologists and the COO is taking a lead on trying to sort the issues with the Christie
- Trust successful in securing funding to support the implementation of the best-timed pathway – this should support 62-day performance.

WWL – Enhanced surveillance (Provider)

- No clinical/medical oncology attendance at LMDT. Discussions with the Christie ongoing. Clinical supervision attendance not achieved. No named stoma nurse or psychosocial/psychosexual counsellor (however not core members of the MDT).
- SMDT provided by WTWA

Local Colorectal Services

Christie – Routine surveillance

SRFT – Enhanced surveillance (Provider and commissioner)

- Service to review the number of surgical procedures undertaken and works to become compliant on the 20 cancer resections per consultant. Continued Commissioner monitoring

Bolton – Routine surveillance

- Potential reputational damage to the service from inaccurate NBOCA return. Considerable support from the trust will be required to prevent repetition in this (and potentially others) tumour group. National audit process managed at local level. Deep dive into data issues with learning being shared across all sites and has been escalated to cancer board. New processes within the trust for sign off and being monitored by cancer board.

Tameside – Routine surveillance

Stockport – Enhanced surveillance (Provider)

- Awarded straight-to-test (STT) funding – in the process of recruiting to enable implementation.
- Also received funding to implement stratified follow-up in low to medium risk patients who have undergone colorectal cancer treatment.
- Oncology attendance at all MDT meetings.

WWL – Routine surveillance

PAHT (Oldham) – Enhanced surveillance (Provider and commissioner)

- Continued 62-day performance issue

MFT (MRI) – Enhanced surveillance (Provider)
- Cover for core MDT member roles to achieve 95%

MFT (WTWA) – Enhanced surveillance (Provider)
- Oncology cover to be solved between MFT and Christie

Haemato-oncology Services
PAHT (Oldham) – Enhanced surveillance (Provider and commissioner)
- Although the CCG perceives the surveillance to be a provider-led action we will continue to work with the trust to offer support for this action.
- CNS to be trained to level 2 psychology training
- Treatment summaries completed by CNS – which template is being used as not included in figures
- Work Programme to be updated after each Q&P/Business Meeting and then disseminated to all MDT Members
- Reconsider establishing MDT Business meetings to allow the full MDT to contribute as not all able to attend the Haematology Q&P meeting
- Audits to be added to Work Programme
- STT CT scans to be added to Work Programme
    - Discussions needed with the GM Cancer Pathway Board as GPs have reported they are not happy to monitor MGUS and CLL patients

Tameside – Routine surveillance
Christie – Routine surveillance
SRFT – Routine surveillance
MFT (MRI) – Enhanced surveillance (Provider)
- Provide core cover for MDT personnel.

Unknown Primary Services (CUP)
Bolton – Routine surveillance
- MDT quoracy now achieved

Christie – Enhanced surveillance (Provider)
- Comment says routine surveillance

PAHT (Cross-site) – Enhanced surveillance (Provider)
- Monitor proportion of meetings which are quorate. Commissioners require a contingency plan to be developed and assurance from the provider to improve level of attendance.

SRFT – Enhanced surveillance (Provider and commissioner)
- Unable to cover CUP MDT in periods of absence. Cover arrangements are still under review by SRFT and assured to provide an update to the CCG.

Stockport – Enhanced surveillance (Provider)
- Single CNS providing Acute Oncology (AO) cover – some ad hoc cover by visiting oncologist and telephone calls to tertiary care (24/7 arrangement).

- Business case submitted to provide funding for a second CNS to support CUP and AO service – outcome awaited.

Tameside – Enhanced surveillance (Provider)
- MDT quoracy/cover arrangements

WWL – Routine surveillance

MFT (WTWA) – Enhanced surveillance (Provider)
- Cover for palliative care representative at MDT

MFT (MRI) – Enhanced surveillance (Provider)
- Cover for palliative care representative at MDT

Acute Oncology Services
Christie – Routine surveillance
SRFT – Routine surveillance
Bolton – Routine surveillance
Tameside – Routine surveillance
WWL – Routine surveillance
PAHT (Fairfield) – Enhanced surveillance (Provider)
- CCG aware of risks with 7-day working and continuing and are continuing to work with the trust to ensure a sustainable offer moving forwards.
- CCG actively involved in the PAHT internal quality assurance process including a review of acute oncology

PAHT (NMCO) – Enhanced surveillance (Provider)
- Conflict regarding rotas – assurance of 7-day service required - There is an issue with providing 7 day a week AO cover across all the PAHT sites and although the service has been in place since December 2018, there are some weekends where there is no cover. Therefore, the AO service under instruction and oversight from Lead Cancer Nurse is auditing this and results of the audit are available if required.

PAHT (Oldham) – Enhanced surveillance (Provider)
- CCG aware of risks with 7-day working and continuing and are continuing to work with the trust to ensure a sustainable offer moving forwards.
- CCG actively involved in the PAHT internal quality assurance process including a review of acute oncology

PAHT (Rochdale) – Enhanced surveillance (Provider)
- Trust to monitor the impact of the current staffing model which does not adequately support a 7-day service if there is both annual leave and sickness in the team.

Also need to update the commissioners on the situation regarding data collection in light of the 12-month issues with Somerset Cancer register and reverting to the MDS dataset. As there are issues with collecting data on Somerset for AO, the team are using the GM AO MDS, which is reported on at AO Pathway Board on a quarterly basis – I can give you more info if you need it.

- Update required on the move to improving the nursing allocation by reducing the number of consultant PA sessions and converting these to nursing hours. Commissioners would like to know what this will look like.

Stockport – Enhanced surveillance (Provider)

- There is a risk around the CNS providing AO cover – there is some ad hoc cover by the visiting oncologist and tele[hone cover from a tertiary service 24/7.
- A business case has been submitted to provide funding for a second CNS to support the AO service.

MFT (MRI) – Enhanced surveillance (Provider)

- Clinical oncology cover required to be agreed between MFT and Christie

MFT (WTWA) – Enhanced surveillance (Provider)

- Clinical oncology cover required to be agreed between MFT and Christie

Conclusion

The board is asked to note and ratify this report and the ongoing actions required by providers and commissioners.