GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Agenda

Meeting time and date: Monday 22nd July 2019, 3-5pm.

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

Chair: Roger Spencer.

#	Item	Type	To	Lead	Time
1	Welcome and apologies	Verbal	-		
2	Minutes of the last meeting	Paper 1	Approve		
3	Action log and matters arising	Paper 1	Note		5’
4	GM Cancer Board Terms of Reference (Draft)	Paper 2	Discuss	Roger Spencer/ Dave Shackley	15’
5	62d Cancer Performance – Sustainability Plan-Short/ long term	Presentation	Approve	Susi Penney	15’
6	GM Cancer Locality Visits – final Report from Commissioning team	Paper 3	Approve	Adrian Hackney	15’
7	Greater Manchester Cancer Pathway Board Leadership update	Paper 4	Discuss	David Shackley	10’
8	GM Cancer led Transformation Projects & Risk Register	Paper 5 Paper 6	Approve	Darren Griffiths/ Alison Armstrong	15’
9	Rapid Diagnostic Centre’s: Next Steps for GM Cancer Alliance 2019 – 2020	Paper 7	Discuss	Sarah Taylor/ Sue Sykes	15’
10	GM Cancer communications Brief	Paper 8	Discuss	Dave Shackley	10’
11	User Involvement Update	Verbal	Discuss	Ian Clayton/ Nabila Farooq	10’
12	Papers for information ▪ Radiotherapy network ▪ Cancer Surgical Transformation	Paper 9 Paper 10	Approve	David Shackley/ Claire O’Rourke	10’
13	AOB: GM Cancer Conference	Paper 11	update	Dave Shackley	
14	Future Meeting Dates: ▪ 16th September 10-12pm ▪ 28th November 10-12pm				

GMCA GREATER MANCHESTER COMBINED AUTHORITY

Paper number 1

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board
Minutes and Actions

Meeting time and date: Thursday 23rd May 2019 16:00-17:30

Venue: Meeting Room 6, Trust Admin HQ, The Christie Hospital.

Members in attendance			
Name	**Role**	**Organisation/Representation**	**Attendance 2019/20**
Carolyn Wilkins (CW)	Co-Chair & Chief Executive Officer	Oldham Council	2/2
Roger Spencer (RS)	Co-Chair & Chief Executive Officer	The Christie NHS Foundation Trust	2/2
Dave Shackley (DS)	Director	GM Cancer	2/2
Claire O'Rourke (COR)	Associate Director	GM Cancer	2/2
Fiona Noden (FN)	Chief Operating Officer	The Christie NHS Foundation Trust	1/2
Susi Penney (SP)	Associate Medical Director	GM Cancer	2/2
Kate Rogerson (KR)	Transformation senior programme manager	Transformation Unit	1/2
Cathy Heaven (CH)	Chair of Cancer Education	The Christie NHS Foundation Trust	2/2
Roger Prudham (RP)	Deputy Medical Director	Pennine Acute Trust	2/2
Lisa Spencer (LS)	Director of Transformation	Salford Royal NHS Foundation Trust	2/2
Ian Clayton (IC)	User Involvement Rep PaBC	Macmillan User Involvement Programme	2/2
Kath Nuttall (KN)	Regional Manager for North	CRUK	1/2
Caroline Davison (CD)	Deputising for Darren Banks	Manchester Foundation NHS Trust	1/2
Cheryl Lenney	Executive Director of Nursing	Manchester Foundation NHS Trust	1/2
Louise Sinnott (LS)	Head of Place-based commissioning GM	Specialised Commissioning	1/2
Tracey Wright (TW)	Deputising for Mike Clark	East Cheshire NHS Foundation Trust	1/2
Darren Griffiths (DG)	Associate Director of Finance	GM Cancer and Cancer Commissioning	2/2
Martin Ashton (MA)	Head of Public Health Operations	Greater Manchester Health and Social Care Partnership	1/2
Chris Harrison (CH)	Executive Medical Director	The Christie NHS Foundation Trust	1/2
Rob Bellingham (RB)	Interim Managing Director GM joint commissioning team	Greater Manchester Health & Social Care Partnership	2/2

Guests in attendance		
Name	**Role**	**Organisation**
Zahra Batool (ZB)	Senior Team Administrator	GM Cancer
Claire Goldrick (CG)	Pathway Manager	GM Cancer
Paula Daley (PD)	Macmillan User Involvement	Macmillan, GM Cancer
Alison Armstrong (AA)	Programme Lead	GM Cancer
Alison Lewin (AL)	Associate Director of Commissioning	GM Cancer
Sarah Maynard Walker (SMW)	Programme Lead	Transformation Unit

Apologies			
Name	**Role**	**Organisation**	**Attendance 2019/20**
Nabila Farook	User Involvement Rep	Macmillan User Involvement	0/2

1. Welcome and Apologies	
Discussion summary	RS welcomed the Board to the meeting and members introduced themselves around the table. Apologies were noted. RS briefly noted the Board's attendance and requested support of Board members in representing fully their constituencies and bodies they represent in order to deliver and implement the Cancer Plan. The Board needs everyone to be properly engaged.
Actions and responsibility	No further actions.

2. Minutes of the last meeting	
Discussion summary	Minutes of the last meeting were approved as a true record.
Actions and responsibility	No further actions.

3. Action log and matters arising	
Discussion summary	RS updated the Board on DS's new role as SRO and Director of Greater Manchester Cancer following a formal process involving Jon Rouse, Chief Officer of the GMHSCP and the co-chairs of the GM Cancer Board. This involved a transfer of responsibilities to DS in his new capacity. RB to provide an update on further developments in commissioning alongside updating the Board on on-going actions relating to 'refreshing' the terms of reference later in the meeting.
Actions and responsibility	No further actions.

4. GM Cancer Priorities 2019/20

Discussion summary	The key priorities were highlighted and RS suggested that there is a need to ensure that the Cancer Board has visibility of the transformation funded programmes, so the Board acts as an assurance and supportive entity to the delivery of the key elements of the GM Cancer plan. In the last meeting, it was decided that the Board should agree some proposed key priorities for the remainder of the financial year. The GM cancer plan highlights many priorities that should be addressed as an alliance and as a system. DS briefly detailed 3 main phases that GM Cancer as an alliance would like to focus on in the immediate future, and this financial year: - Tackling 62 day pathway robustly as a system - Delivering priority 1 (transformation funded) projects - Planning guidance for CCGs – system 'must-do's' (national requirements) In the event that additional funding is made available, DS noted that it would be important that there was an agreed list of priority areas for investment. To that end GM Cancer intends to proactively identify potential areas of investment with a view to working with the Board to agree the relative priorities. The patient priority includes having psychological support which is not currently mentioned in the key priorities. IC informed the Board that this ranks as a top 3 concern/priority for patients. RS reiterated that the Board needs to be focused in its objectives which are providing support and oversight of delivery plans and building relationships with commissioners to ensure that properly informed decisions can be made about future funding. The cancer programme needs to be properly networked and aligned to ensure the objectives are met. CW suggested that location/place should be linked into this item. Providers and Commissioners need to focus on this in order to track impact in localities.
Actions and responsibility	RS and DS to revisit this agenda items at future Board meetings to track progress and consider points made at upcoming meetings.

5. 62d Cancer Performance	
Discussion summary	62 day performance is one of the significant issues that the Board is looking to effect. FN provided an update on performance across Greater Manchester and noted that there is failure to achieve this target across the network in the last year, since May 2018. Each organisation has been affected so there is now a desire to move towards a more system-level approach. A provider-led workshop held 2 weeks ago helped to assess where the breaches and problems are. FN informed the Board that the main discussion point at this workshop related to the

	appointment of a senior person as Programme Director who will be able to help deliver support to the system/individual providers to share learning, and encourage delivery of the Cancer Waiting Time standards. The role was endorsed in principle at that workshop subject to clarification about some of the technical aspects to the job description. There was already a broader agreement predating this workshop about this approach which was supported by the Provider Federation Board and GM Joint Commissioning Team. FN asked the Board to support this central proposal (accepting some technical specifications of the job remit needed clarification) with the job description being finalised this week with the Director of Operations Group, then going out to advert within as short a period of time as possible, given the pressures on meeting the 62d standard. The Board endorsed this approach, supporting an urgent appointment, ideally with progress made in the immediate future, and obtaining agreement relating to the technical details with colleagues as appropriate Linking in to this, IC issued a statement to the Board in which he expressed disappointment in relation to the task and finish group who have not yet met their 12 key recommendations. COR updated members that national data showed that there had been a fall in GM's cancer waiting time (CWT) performance which was more marked than most other alliances and as such needs to be addressed - this Programme Director would help to improve the pathway performance as well as join the networks together.
Actions and responsibility	Board members support producing a job Spec/Role summary and plan to circulate to Director of Operations Group getting agreement on implementation asap. Appoint a Programme Director who will coordinate the CWT GM approach, data and related actions, answerable to the GM Cancer Board Discuss this agenda item at the next meeting.

6. GM Cancer Locality Visits	
Discussion summary	AL was invited to present Paper 4 to the Board. She noted that the paper is a brief interim update on an ongoing agenda item. Currently, 9 of 11 localities have been visited and the key findings have established some commonalities. This include: - Willingness to work together with other localities - Challenges in the workforce - Willingness to improve the screening uptake. 2 localities still need to be visited and an update will be provided in the future. Generally there is positivity from localities especially around transformation updates.
Actions and responsibility	AL and team to revisit and update to be provided at the next board meeting.

7. Cancer Survival in Greater Manchester & Eastern Cheshire	
Discussion summary	DS introduced Paper 5 and provided an update on the 6 key objectives. National statistics show Cancer survival rate in patients after 1 year of diagnosis is 72% but

	figures do not include prostate cancer or children's cancer, and so the figures are of use when benchmarking within England, but not for international comparisons. There has been a steady incremental rise in survival over time related to various improvement initiatives. GM has closed the considerable survival gap that existed. The data is only available for GM and not GM and Eastern Cheshire die to the way the data is collected and presented at national level. Preliminary analysis show that when combining Eastern Cheshire with GM data, the figure improves by approximately 0.25%. The main point to note is that this data is available on the Spark Ricoh portal, which all stakeholders are able to access. This portal is run by the GM Cancer Intelligence team and allows localities to look at various data relating to their own and other localities performance across many types of data. RS noted that the rate of improvement is the best rate in the country currently and this need to be recognised. CW asked the Board what the correlation is between poverty/ deprivation levels and survival rates. Discussions ensued around this issue, but the item will be revisited.
Actions and responsibility	Revisit this agenda item with a focus on poverty levels in comparison to survivability as it is a work in progress.

8. GM Cancer led Transformation Projects Update	
Discussion summary	RS reminded members of the projects underway and see it as a running sequence rather than a detailed update. DG delivered an update on the £10 million provided to lead GM Cancer projects and asked Board members to comment on the report, its format and if anything else needs changing.
Actions and responsibility	ALL to send thoughts and comments about the reporting format to DG. This will be a standing agenda item going forwards.

9. NHS Transformation Unit Programme Update	
Discussion summary	SM-W presented an update to the board, in which OG, Urology and Gynae services were assessed. <u>OG</u> The service in OG is 3 times busier than was expected but the team is working well together. The OG service has received positive feedback from patients. In relation to Prehab4Cancer, the OG team is seeing positive feedback. <u>Urology</u> Open bladder has transferred from MRI to Wythenshawe and a huge piece of work has been undertaken for emergency provisions for Urology cancer. Plans for a single organ specific, city wide series of SMDT's have been agreed. . <u>Gynae</u> Collaboratively drafted service specifications are out for feedback, including review through

	ECAP. The approval process is planned for June/July 2019. The key ambitions are: 1. Publish outcomes no later than 2021 2. Data driven 3. Increased participation in research 4. Service users should be active and equal participants 5. Review of diagnostic units SMW discussed some common challenges across these groups including: 1. System response/resistance to the changes being implemented 2. Capacity to participate in the change process 3. Timeframe to deliver 4. Implementing the single service MDT models a. Job plan changes and single system processes to deliver/enable the MDT b. Capacity of radiology and pathology The approach of the Transformation Unit to addressing these challenges was briefly explained.
Actions and responsibility	TU team will provide updates to the GM Cancer board and meet with GM User Involvement Team to ensure patients affected by cancer are represented at meetings on cancer surgery transformation.

10. Update on Cancer Screening in Greater Manchester	
Discussion summary	MA updated the board briefly and presented paper 8. Bowel and breast screening uptake have improved but they are still below the national rate which is a point of concern. Cervical screening uptake continues to reduce so this needs to be addressed and things need to change to ensure figures rise. Testing of cytology samples at CMFT has seen an increase of activity in Q4 by an extra 25% which is the result of a national marketing campaign. The budget held currently is for the provision of services but extra investment is needed for bowel and breast screening programmes. RS informed the board of his attendance at the National Cancer Board where he was allocated the task of chairing the task and finish group for cancer early detection.
Actions and responsibility	Revisit this item as it is a top consideration for GM Population Health Team

11. User Involvement Update	
Discussion summary	The issues and views of PABC had been provided as each agenda item was discussed so no further updates were noted.
Actions and responsibility	An update to be provided by IC and UI team at the next meeting.

12. Future Meeting Dates	
Discussion summary	RS and CW thanked the Board members and guests for attending. Future meetings are: 22nd July 2019 15:00-16:30 Doubletree Hilton Hotel, One Piccadilly Place 16th September 2019 10:00-12:00 Doubletree Hilton Hotel, One Piccadilly Place 28th November 2019 10:00-12:00 Doubletree Hilton Hotel, One Piccadilly Place
Actions and responsibility	No further actions.

Paper number 1

Action log

Prepared for the 22nd July meeting of the GM Cancer board

	ACTION	AGREED ON	STATUS
1	**Item 4. GM Cancer Board Development** Cancer workforce review	30.04.19	*Workforce paper to be reported to July board 2019.* ***Interviews completed for workforce lead***
2	**Item 5. Proposed GM Cancer Board deliverables** Bring back to Cancer board a proposed set of 6-12 month priority objectives for the next Cancer Board (May 2019) Refresh of GM Cancer plan	30.04.19	***Agenda Item 4 for GM Cancer board 23.05.19*** *Agreed to report to GM Cancer board in September 2019*
3	**Item 6. GM Cancer plan update: focus on Transformation projects** Required as standing agenda Item and update at each board	30.04.19	***Agenda Item 8 for GM Cancer board 23.05.19***
4	**Item 7. 62 day cancer performance** Report to next GM cancer board on the 10th May 62d CWT workshop Recruit to the post of senior programme director for cancer performance in GM & EC as soon as practicable	30.04.19	***Agenda Item 5 for GM Cancer board 23.05.19*** Interview to be agreed by 24.05.19
5	**Item 8. Locality visits and understanding local cancer commissioning** Paper to summaries key updates and findings	30.04.19	***Agenda Item 6 for GM Cancer board 23.05.19***

Paper number 2

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	22nd July 2019	
Title of paper:	GM Cancer Board Terms of Reference (TOR)	
Purpose of the paper:	To provide the board with a draft proposed TOR for the newly formed GM Cancer board	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	✓	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes	The GM cancer TOR stipulates the importance of patients being key members of the board to ensure patient experience is key to the ongoing programme of work of the board.	
Improved patient experience	Improving outcomes and access and reducing variation are two key factors in patient experience.	
Reducing inequality	The delivery of the GM cancer plan, aligned with the GM cancer board, is heavily predicated on demonstrating a reduction in inequality across the system.	
Minimising variation	There is identified variation across the cancer system in GM and it is the GM Cancer board responsibility to monitor and review key developments to improve this, with variation and best practice identified and shared as a result with the board.	
Operational / financial efficiency	Delivery via GM Cancer boards infrastructure of the financial and operational efficiencies described in the GM Cancer Plan.	
Author of paper and contact details	**Name:** Rob Bellingham **Title: Managing Director,** Greater Manchester Joint Commissioning Team **Email:** robbellingham@nhs.net	

Greater Manchester Cancer Board

Draft Terms of Reference

July 2019 (version 4)

1. Aim of the board

The Greater Manchester Cancer Board aims to ensure the delivery of the ambitions set out in the Greater Manchester Cancer Plan and the cancer related requirements set out in the NHS Long Term Plan.

The Greater Manchester Cancer Board will develop and oversee delivery of objectives (and associated metrics) that span the complete cancer pathway:

- Improving prevention, screening and early detection
- Delivering faster and better diagnosis and meeting the cancer waiting time targets set out in NHS planning guidance
- Improving outcomes with a focus on survival
- Improving patient experience
- Delivering high quality, compliant, coordinated and equitable services
- Improving services for people living with and beyond cancer and at the end of life
- Increasing research and innovative practice
- Increasing Cancer Education / training for Cancer professionals

2. Roles of the board

The Greater Manchester Cancer Board represents all partners in the Greater Manchester cancer system and provides integrated whole-system leadership. The board is founded on the core Greater Manchester Health and Social Care Partnership principle of co-design between providers, commissioners, clinicians and service users, as set out in *Commissioning for reform: The Greater Manchester Commissioning Strategy*.

The board has a number of roles:

1. It is responsible for the implementation of the Greater Manchester Cancer Plan, based on the national cancer strategy but reflective of the local circumstances and ambitions described in the GM Plan
2. It will oversee delivery of the Cancer Performance standards set out in the NHS Long Term Plan and the GM Cancer Plan
3. It will co-produce recommendations on the priorities for cancer commissioning for the Joint Commissioning Board.
4. It will ensure that there is integration of cancer services across the whole system and hold the system to account for its performance across the whole cancer pathway, from

prevention to end of life care. It will provide a mechanism for scrutiny and collective accountability across partner organisations.

5. It will actively manage and hold to account Greater Manchester's cancer clinical network

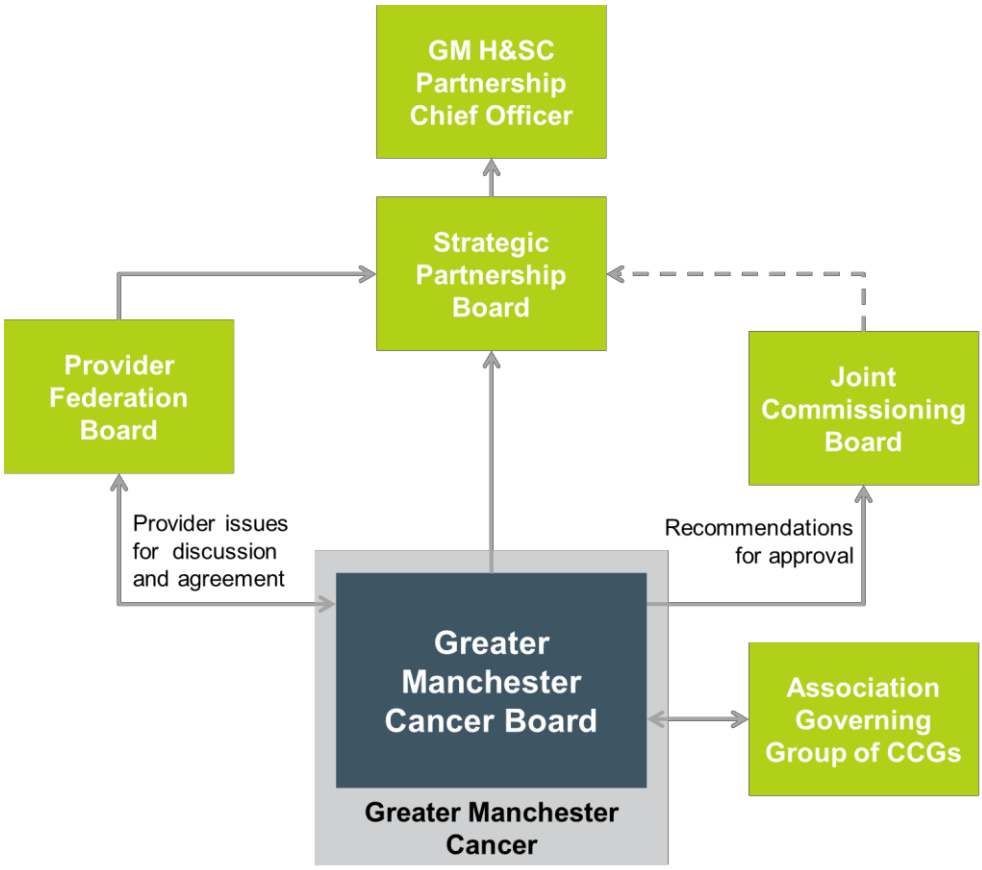
6. It will agree a work plan, setting out the funding and infrastructure required to support its delivery. It will report regularly to all relevant parts of the Greater Manchester Health and Social Care Partnership and produce a public report annually on progress against its plan.

4. Accountability and decision-making

The Greater Manchester Cancer Board sits within the governance and accountability structures of Greater Manchester Health and Social Care Partnership. It therefore has relationships with the Joint Commissioning Board and the Provider Federation Board. Ultimate accountability is to the GM Partnership Executive Board (PEB).

The Greater Manchester Cancer Board will make recommendations to the Joint Commissioning Board. Issues that require more dedicated provider-only discussion prior to a decision being taken or a recommendation being made to the Joint Commissioning Board will be referred through the Provider Federation Board.

Figure 2: Cancer governance in Greater Manchester



5. Membership

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

The membership of the board is set out in the table below. The membership has been formed from the need to balance inclusiveness of all relevant groups with the need to keep the board relatively small and a functioning decision-making unit.

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

The board will focus on a particular theme for part of each of its meetings. The board will therefore invite expert representatives of other bodies or organisations as its agenda requires.

Similarly organisations or bodies may make a request to the chair that they are directly represented at a particular meeting or agenda item.

Greater Manchester Cancer Board	Numbers
VOTING MEMBERS	
Co-Chair (Commissioner Accountable Officer)	1
Co-Chair (Provider Chief Executive)	1
Lead GP (nominated by CCG Clinical Chairs)	1
GM Health & Social Care Partnership team	1
NHS England specialised commissioning	1
Provider trusts	4
Primary care providers	1
IN ATTENDANCE (STAKEHOLDERS)	
People affected by cancer	2
Third sector advisory group representatives including CRUK/ Macmillan for example	2
IN ATTENDANCE (DELIVERY)	
Director – GM Cancer (SRO)	1
Associate Medical Director-GM Cancer	
Associate Director – GM Cancer	1
Managing Director – GM Joint Commissioning	1
Director of Commissioning – GM Cancer	1
Chair of Trust Directors of Operations Group	1
Chair of Cancer Education Manchester	1
MAHSC Cancer Domain Academic Lead	1
GP Federation board	1
Population health and Screening	1

Members of the Greater Manchester Cancer Board's support team will also be in attendance.

7. Frequency of meetings

The Greater Manchester Cancer Board will meet at least bi-monthly. Papers will normally be circulated 10 days prior to each meeting to allow members to consult with partners across the system on their contents.

8. Quorum

For quorum to be achieved, more than half of the voting members (or their nominated deputy) must be present, with at least one commissioner and provider present.

9. Voting

The nature of the Board means that we do not expect voting to be required on a regular basis. However, should a vote be required, a resolution will be passed based on a simple majority of those voting members, (or their nominated deputies), present.

10. Term and review

The Greater Manchester Cancer Board will have an indefinite term. It will review its terms of reference, membership, work plan and infrastructure requirements annually.

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Greater Manchester Cancer

Paper number 3

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	22nd July 2019	
Title of paper:	GM Cancer Locality Visits	
Purpose of the paper:	To update the GM Cancer Board on locality visits undertaken and proposed actions / key issues	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	✓	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes	The paper updates the board on the outcome of the locality visits, the content of which addresses the implementation of the GM Cancer Plan across the localities, with the key aims of the plan to improve outcomes and patient experience and reduction in variation across GM.	
Improved patient experience	Improving outcomes and access and reducing variation are two key factors in patient experience, addressed by the locality discussions outlined in this report.	
Reducing inequality	The delivery of the GM cancer plan is heavily predicated on demonstrating a reduction in inequality across the system.	
Minimising variation	The locality visits outlined in the report have enabled variation to be identified and addressed, with variation and best practice identified and shared as a result of the locality visits described in the report.	
Operational / financial efficiency	Delivery via commissioning infrastructure of the financial and operational efficiencies described in the GM Cancer Plan.	
Author of paper and contact details	**Name:** Alison Lewin **Title:** Associate Director of Commissioning – Cancer Services **Email:** alison.lewin@nhs.net	

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

GM Cancer Locality Visits

Date: 22nd July 2019
Title: GM Cancer Locality Visits
From: **Adrian Hackney, Director of Commissioning – Cancer Services**

1 Context and purpose of the report

This report follows the presentations to the GM Cancer Board in April and May 2019 on the current position in relation to Cancer services commissioning in Greater Manchester and Eastern Cheshire, which included details of a series of locality visits which commenced in early April 2019. Visits to all 11 Greater Manchester & Eastern Cheshire localities have now been undertaken.

The purpose of the visits has been to establish a 'peer to peer conversation' approach, sharing best practice, progress and determining ways in which the whole system can continue to work together to deliver the GM Cancer objectives and metrics, therefore improving the outcomes for people with cancer in GM. The visits have provided an opportunity to strengthen relationships between GM Cancer and the localities (including Eastern Cheshire) and further develop ways of joint working and mutual support.

This report provides a summary of the outputs from the visits, locality level details, and recommended actions to take as a result of the visits.

This report has already been shared in draft format with the Cancer Commissioning Managers in the 11 localities.

2 Locality Visit Form and Attendance

All 11 locality visits have been undertaken. As outlined in the previous interim report, each visit has been chaired by the Director or Associate Director of Commissioning – Cancer Services and attended by colleagues from the GM Cancer team and GM Joint Commissioning Team. A standard agenda has been followed for each visit, to provide structure to a conversation about progress in the locality with the delivery of the GM Cancer objectives:

- GM Cancer metrics / national planning guidance
- GM Cancer transformation schemes & key projects
- Locality issues:
  - Contracting and finance – locality
  - Workforce
  - Primary care
  - Learning and sharing good practice

The notes of each visit have been compiled and were shared with localities to confirm accuracy before compiling this final detailed report. This report has also been shared with the Greater Manchester & Eastern Cheshire Cancer Commissioning Managers in the 11 localities to enable them to comment and amend before presentation to the wider GM system. The sharing of this report in draft format at the earliest opportunity also enabled the localities to make contact with one another where there were identified areas of good practice.

Representation from within localities: A number of the national priorities for cancer cut across commissioning functions, for example improving early stage diagnosis will involve interventions in public health, screening, primary care and hospital cancer services. Following discussion at the GM & EC Cancer Commissioning Managers meeting on 14th February, an email was sent on 28th February to all Cancer Commissioning Managers asking them to convene representation from across the CCG / Strategic Commissioning Function, and not just 'Cancer Commissioning staff'. It was recommended that they involve Primary Care (delegated) Commissioning, Public Health, Clinical Leadership, Finance and Planning/Business Intelligence. It was also proposed that provider colleagues be invited to participate. Representation across the 10 localities is summarised below:

Locality	Comm	PH	PCC	GP	Prov	Fin	BI/P	Other
Bolton	✓		✓	✓	✓	✓	✓	✓
Bury	✓	✓		✓	✓		✓	
Eastern Cheshire	✓		✓	✓	✓		✓	
Heywood Middleton & Rochdale	✓	✓		✓	✓		✓	✓
Manchester	✓	✓	✓	✓	✓	✓	✓	✓
Oldham	✓			✓	✓	✓		✓
Salford	✓	✓	✓	✓	✓	✓		
Stockport	✓			✓			✓	✓
Tameside & Glossop	✓		✓		✓			✓
Trafford	✓	✓		✓		✓	✓	
Wigan Borough	✓	✓	✓	✓		✓		

Comm – Cancer Commissioning Mgr / Senior Commissioner / Director of Commissioning
PH – Public Health
PCC – Primary Care Commissioning
BI/P – Business Intelligence / Performance
Prov – Provider
Fin – Finance

3 Key Findings and Themes - Summary

Initial findings and common themes from the visits undertaken to date include:

- **Screening and early identification**: Good discussions have been had relating to the work in localities on the uptake of screening programmes, including some strong models of community engagement. There is an understanding of the issues faced relating to screening, and a willingness to work with GM Cancer and the Partnership to address these issues has been commonplace. This is an area where localities could share their approaches and provide support to colleagues in other areas to deliver local solutions in addition to support from GMHSCP.

Public awareness and communication has been identified as a key issue which could be supported at GM level, for delivery and 'amplification' locally – the design of core messages centrally, for delivery locally through the robust communication channels in place via CCGs and / or Local Authorities / Strategic Commissioning functions. In addition to messages on screening uptake, a GM level significant campaign on late presentation was proposed, to enable a targeted delivery to appropriate areas within localities.

- **Smoking:** There was marked variation reported in the form of the locality models for smoking cessation, and the extent of support available, but widespread support for this as a priority area, and for the implementation of the CURE programme. The presence of public health colleagues in the locality meetings (where this was the case) provided for a more in depth discussion on this topic and the localities' strategies for smoking cessation / tobacco control.

- **Emergency Diagnosis:** There was a widespread willingness to address this where it remains an issue and to learn from areas where reductions have been seen. The view in some localities has been that a Significant Event Analysis approach can contribute to a reduction in emergency diagnoses. A view was also shared that the increase in suspected cancer referrals should have a positive impact on the emergency diagnoses (i.e. reduction in the latter). There was widespread support for GM Cancer to facilitate a methodology to identify and address issues relating to emergency presentation and diagnosis to supplement the work ongoing in localities. Initial contact has been made with the Utilisation Management team in Health Innovation Manchester to see what support they may be able to offer.

- **62 days and delivery of cancer waiting time standards:** All localities gave a clear description of how this is managed in their localities, what the key issues are, and what actions have been undertaken to address areas of concern, including the development of plans across the system. The level of detail provided depended in part on whether or not the provider organisation was in the room. This is not to suggest that the commissioner representatives were unable to offer this level of detail, but that a system wide discussion led to a more detailed presentation of the key issues.

- **One Year Survival:** The updated information on 1 year survival was shared after some of the locality visits had taken place, but there was a general view that further work needs to be undertaken to understand the correlation between screening / early diagnosis / emergency presentation and the 1 year survival figures. This will be addressed from a commissioning perspective via the Cancer Commissioning Managers group in the first instance.

- **Primary Care:** In some GM localities, but not all, the implementation of primary care standards which include elements relating to the identification and referral of suspected cancer patients / education in relation to cancer has been supported with additional funding. All localities were able to give a good account of the primary care engagement and the degree to which the primary care standards have been formally implemented, and the level of funding attributed to this.

- **Workforce:** Common issues have been reported across all localities relating to diagnostics, radiology, and recruitment / retention of key staff groups. The recruitment and retention issues reported did vary depending in part on the level of direct service delivery in the locality (e.g. posts

within organisations with more specialist and advanced services were reported as being less challenging to recruit to). All welcomed the appointment of a GM Cancer workforce lead to undertake a GM wider review of workforce issues relating to cancer pathways.

- **GM Transformation Schemes:** All localities welcomed the provision of information relating to the GM Cancer Transformation Funding (TF) schemes, and the proposed implementation, ongoing evaluation and approach to the sustainability discussions. A common message was the need to consider the fact that there are a number of Transformation Funded projects in each locality, not just those funded by GM Cancer TF, along with the core services commissioned by the CCGs and Public Health commissioners. The request was to be aware of this when presenting proposals to localities for consideration /prioritisation, and making the legacy of the transformation funding a different approach to the investment of the whole budget. There were also requests to ensure the financial opportunities reflected in any proposal are realistic. The GM Cancer Commissioning Team have taken this on board and are in the process of working with the GM CCG Deputy Chief Finance Officers on the implementation, evaluation and sustainability process. The GM Commissioning Team will engage Eastern Cheshire colleagues as appropriate to ensure that the evaluation and learning from projects supported with GM Cancer TF is shared with them to enable discussions within their governance processes as required, whether their populations are directly involved or not.

4 Areas of Good Practice / Sharing of Information

Attached at **Appendix 1** to this report is detailed feedback from the locality visits, by theme. The purpose of sharing this level of detail is to enable the localities to communicate and find out more information from their peers in other localities. Cancer Commissioning Managers have been encouraged to contact peers in other localities to learn from approaches taken to address common issues and challenges.

Governance
Most areas reported the existence of a 'Cancer Board' or locality based cancer forum, with stakeholder representation from across the locality. Whilst GM Cancer have not yet obtained details of these fora, if GM localities feel it would be beneficial to look at how others deliver this in their localities, the information can be requested, collated and shared. Some localities proposed that members of GM Cancer could attend locality 'Cancer Boards' to present specific topics and updates on the implementation of the GM Cancer Plan.

Some areas reported the existence of a locality version of the GM Cancer Plan and / or a locality plan based on national guidance for cancer. As above, if localities feel it would be beneficial to see examples from elsewhere, GM Cancer could request, collate and share. Localities should note that the GM Cancer Plan is to be refreshed, and locality engagement will be part of this process of reviewing and refreshing the current plan.

5 Key Actions

As referred to above, the detailed findings of the locality visits, included in appendix 1, have been shared with the Greater Manchester & Eastern Cheshire Cancer Commissioning Managers. There are some initial key proposed pieces of work arising from the locality visits, which are as follows:

- **Decommissioning**

There was a strong message from some localities that GM support for the identification of elements of pathways and / or services which could be decommissioned to support the ongoing development of cancer pathways and services would be beneficial. The GM Cancer Commissioning team will work with the system to determine a way forward to support this across GM & EC, with locality engagement and steer from a commissioner and provider perspective, with the input of the user involvement team to ensure robust PABC involvement.

- **Primary Care**

As referred to in the section above, and in detail in the appendix, there is variation in how primary care standards have been implemented across Greater Manchester. It is proposed, that working with the Greater Manchester Health & Social Care Partnership Primary Care Commissioning team, GM Cancer co-ordinate out a piece of work to determine and quantify the impact of the different approaches to primary care engagement – a solution focused evaluation of the effectiveness and impact of the different approaches taken.

This approach will also enable GM Cancer and the GMHSCP to scope how the screening team can work closer with the commissioners of General Practice to address issues relating to primary care delivery of screening programmes, where the contractual levers and responsibilities sit with CCGs.

A more detailed progress report will be presented to the GM Cancer Board in September which will include:

- Outline of funding of primary care standards by CCGs and how this compares with the delivery of GM Cancer standards for screening, early diagnosis and emergency presentation.
- Gateway C figures per locality – registration and completion
- Primary Care Networks update – a summary of the development and implementation of the Primary Care Network model across GM, the initial priorities and form, and the introduction of Directed Enhanced Services from April 2020, some of which refer specifically to cancer diagnosis and support
- GP Contract and QOF (Quality and Outcomes Framework)
- Suspected Cancer Referrals – paperwork, standard referral forms and processes
- CCG GP leads' involvement in GM Cancer work

- **Locality 'Stories' and Hypotheses**

The GM Cancer Senior Team will review the outputs of the locality visits, and the data shared to support them, and will consider how to evaluate the 'stories' the data appear to tell. In some areas there are comparatively low levels of uptake of screening and early diagnosis, comparatively high levels of emergency presentation diagnoses, yet improvements in and comparatively high levels of 1 year survival, either overall or at tumour specific level.

This is an issue which has been discussed at a number of the locality visits and is worthy of further exploration to improve the system understanding. CCG commissioners have specifically asked that the population of the CCGs (actual and weighted) are taken into consideration when undertaking this analysis. Public Health and Commissioning representatives from the GM teams are meeting to discuss this in the first instance and develop a proposal for how to take this forward.

6 Recommendations

GM Cancer Board is asked to note the content of this report, provide any feedback and support the key actions outlined above.

Appendix 1

Details of feedback from GM Cancer : Locality Peer to Peer Visits April – June 2019

Screening and Early Identification

As noted above, there were detailed discussions in the locality meetings on the issues relating to screening and early identification. Examples of good practice in this area, along with key issues identified, include:

- Effective approach in the Wigan locality to addressing the screening uptake through community engagement rather than focusing purely on GP practice engagement to increase uptake of screening – staff member in post to support this. Work in HMR and in Trafford on BME community engagement in screening programmes.

- HMR have developed a range of business cases for pathways to promote early presentation and diagnosis

- Localities where there aren't imminent plans to implement lung health checks were all keen to ensure they're kept sighted on the implementation of projects in other localities (Manchester, Salford and Tameside & Glossop), so asked GM Cancer representatives to ensure updates are provided on the GM position with lung health checks.

- Localities keen to understand the detail of the Cancer Champion programme – now will be part of the Screening Engagement Service offer at GM level.

- HMR have established a multidisciplinary steering group for screening, building in some cases on insight work undertaken in the locality. Primary Care workstream in place to support this, with the involvement of CRUK and Rochdale Health Alliance. The action plan has recently been refreshed. Tameside & Glossop have a similar structure in place led by the Public Health directorate and with wide locality support / engagement. Similar in Wigan with a screening sub-committee to their locality cancer forum.

- HMR have a population health transformation plan and programme in place which they are happy to share with other localities. The expectation is that this will address issues relating to cancer incidence and identification, and will address the variation within the HMR locality.

- Consistent message regarding locality 'amplification' of GM-led messages being a strength in GM, to support early presentation and identification

- Tameside & Glossop examples of locality redesign of diagnostic pathways with STT in colorectal, and lung pathway Chest X-Ray / MR scan

- CRUK support being provided in Oldham (includes the CRUK Facilitator working with practices where screening uptake is low), Tameside & Glossop, HMR, Bolton to identify and work with practices with low uptake of screening programmes.

- Data packs developed at a practice and neighbourhood level in T&G to support practice and neighbourhood discussions – CCG and CRUK joint approach / exercise. Neighbourhood GP meetings have held focused discussions on cancer in routine meetings.

- Acknowledgement across all localities that the implementation of FIT should have a positive impact on screening and early identification.

- Screening included in primary care standards in some localities – see primary care section below

- Requests for support came from most localities with respect to the Greater Manchester Screening Engagement Service – all were keen to participate and work closely where possible.

- Support offered from GMHSCP to link together localities where there are similar issues with engagement in screening programmes – e.g. cervical screening and particular age groups, 25-49yr age group being an issue in more than one locality

- GM support requested for public facing messaging regarding HPV vaccination and screening

- Bury requested more information on opportunities to try the self-sampling cervical screening kits in the locality as a way to improve the cervical screening uptake – GMHSCP to share more information on this when available

- Oldham to roll out FIT for symptomatic patients – expect to do so from July 2019, following GP and secondary care clinician discussion. Approach to this varied across localities – awareness in all but different stages in terms of consideration of implementation

- Direct access breast pathway in place in T&G – without GP referral – tested in one neighbourhood and now open to all

- Consistent message from localities regarding the timeliness of staging data and the ability to see the impact of actions undertaken in a timely way. Issue which would benefit from input from the GM Cancer Intelligence Service.

- Salford plan is to have a locality communication exercise on HPV in September to coincide with the return to school.

- Manchester locality keen to measure the impact of GP texts to patients re screening appointments

- Eastern Cheshire have invested in navigator roles and stressed the value of these roles to patients and professionals, and to delivering waiting time standards

- Wigan Borough CCG reported that they have 350 community cancer champions in the Borough – includes coverage of all care homes – upskilling HCA staff in care homes

- Use of locality social media – CCG, provider and Local Authority – to promote messages relating to screening and early presentation. Specific project in Bolton with Practice Nurse engagement via social media to promote cervical screening

Further information on primary care and early identification / screening included in the primary care section, below

Smoking

Tobacco and addressing smoking rates was confirmed as a priority issue for all localities. In most, whilst smoking rates have dropped, it is acknowledged that they are still high, and that there is significant variation across the neighbourhoods in each locality. Localities have tobacco strategies in place, but different offers for community based smoking cessation support. Support for the roll out of the CURE programme in the localities included in wave 1. Examples of good practice and / or requests for additional support are:

- HMR - 'quit before the op' programme in place

- Some localities were awaiting further guidance from Greater Manchester with regard to the use of E-Cigarettes, namely HMR, Stockport

- Information available if required on a project/study which focuses the approach to E-Cigarette use on areas of deprivation (shared with Stockport and can be shared with others on request). Projects in Salford and in Trafford.

- Trafford 'Stop Before the Frost' campaign

- Request for consideration of a consistent GM wide approach to the coding of people using E-Cigs as 'ex smokers' on primary care systems – an approach being taken in the Oldham locality

- Strong message from localities that the smoking rates vary significantly within localities.

Emergency Presentation and Diagnosis

Where there is a clear and robust process in place for Significant Event Analyses in primary care, this was reported to have an impact on the emergency presentation position.

Where it was referred to as a possible opportunity, localities were supportive of the proposal to approach the GM Utilisation Management Team (now part of Health Innovation Manchester) to see whether an approach could be developed to understand and address the emergency presentation and diagnosis of cancers in the GM localities. Learning will also be taken from the approach that's being developed by the Northern Care Alliance.

- Bury have a robust process in place for SEAs to be undertaken in primary care, a process led by the Macmillan GP. The locality view was that this has been a significant contribution to the success in reducing emergency presentation and diagnoses.

- Bury locality: Pennine Acute Hospital Trust is capturing data as a clinical issue where a patient presents in A&E with bowel cancer to understand why an earlier diagnosis has not been made. PAHT and the CCG to work together consider how the learning from this can be cascaded to support early detection.

- Salford: 5 Practices per year are identified and visited to discuss in detail emergency presentations and diagnoses

- Eastern Cheshire suggestion to include this in GP appraisal process – intention in the locality is to undertake a piece of work within the CCG to review staging, emergency presentation and survival data

- Bolton: Practice level dashboards refreshed for primary care, which include practice rate of emergency presentations per 100,000 population

62 days and delivery of Cancer Waiting Time Standards

There was clear evidence of joint working between commissioners and providers on the understanding of and addressing issues impacting on cancer waiting time standards. Specific examples are:

- North East Sector Cancer Improvement Committee and plan – joint working across the Pennine Hospital Foundation Trust and 4 CCG footprint (including Manchester for the North Manchester element of this). Positive feedback from the locality meetings in relation to the impact of this sector wide working.

- Bury: clinical triage undertaken in primary care of GI referrals – process includes the gathering of intelligence to inform further pathway redesign, not restricted to but inclusive of suspected cancer referrals

- Report from some localities to the encouragement of the use of Advice and Guidance – Bury, Tameside & Glossop

- Bury: establishment of virtual clinics to reduce pressure on secondary care

- Bury: process in place whereby 62 day breaches are identified and reviewed with primary care and senior management input. 6 cases reviewed in detail by tumour site, solutions identified along with improvement themes. This enables specific clinical behaviour to be identified and the appropriate changes to be enacted.

- Community Cancer Support service in place in HMR (launched September 2018). Community Navigator role in development in T&G – project between Macmillan, CCG and T&GICFT

- Request for stratification for more pathways other than breast – capacity releasing as well as service improvement. Evidence based statement requested for commissioners to express this as a commissioning intention

- Support across all localities for the further development of Rapid Diagnostic Centres, and enthusiasm to work with GM Cancer on such developments.

- Significant investment in Navigator roles in Pennine Acute Hospitals NHS Trust to support cancer pathway

- Concerns in some localities re EBUS capacity and timely access (to be addressed in July GMCCM meeting following discussions in Lung Pathway Board)

- T&GICFT delivered a 'Cancer Summit' to a significant number of staff within the organisation, to reiterate the cancer pathways and standards and the roles played by ICFT staff in their delivery. Content was used in a subsequent GP session with secondary care clinical involvement.

- Stockport outlined the success of the tele-dermatology project in identifying early cases, and plans to roll this out to support suspected cancer referrals, working with the GM Cancer Skin Pathway Board. Manchester also reported use of dermatoscopes, as did Wigan Borough CCG, who have identified high referring practices and those with a clinical interest.

- Issues in Wigan with lower GI led to the development of a 'helpful hints to consider prior to submitting two week suspected colorectal cancer referral' document – developed by WWL and the CCG. Can be shared with other localities.

- Development and approval of a case for locality delivery of EBUS – Bolton CCG and Bolton FT

1 Year Survival

Data shared and referred to in the locality discussions on screening, early diagnosis, and emergency presentation / diagnosis. Actions to address 1 year survival position are outlined in the other sections of this report.

Primary Care

Primary Care Quality Schemes: Whilst engagement with primary care was evident in all localities, there was variation across GM in the application of the GM Primary Care Standards, particularly in relation to whether or not they form part of a formal, and funded, primary care scheme. This section of the report includes ways in which the localities are support their General Practice and wider primary care teams

- Cancer (e.g. Gateway C, screening, NCDA) included in primary care standards in: Oldham (Primary Care Plus), Salford (Salford Standard), Manchester (MHCC Neighbourhood Development Scheme), Bury (currently out for consultation), Wigan, Bolton (Bolton Quality Contract)

- HMR require a different and improved approach to the uptake and use of Gateway C, beyond initial registration, and would welcome support from other localities and / or advice from GM on how to progress this further.

- HMR Primary Care Academy established, which has been used to support education re cancer.

- Some localities still have protected time for GP and Primary Care education, which they have used for cancer related sessions, between GPs and secondary care in some instances (Wigan, HMR, Tameside & Glossop). Other areas have delivered 'masterclasses' or regular events specific to cancer to their primary care providers, with secondary care involvement as appropriate (Stockport, Salford, Oldham, Bolton) and regular cancer information in GP communications.

- HMR – The Core Plus contract with Rochdale Health Alliance includes elements relating to cancer in primary care / community settings.

- There were conversations in a number of locality meetings regarding the degree to which CCGs are leading on GP contractual levers and GM need CCG support where GPs are key to improvements, e.g. cervical screening.

- More information required on the NHSE funded link workers and the potential impact for people affected by cancer.

- Proposal from one locality that ensuring NCDA, SEA and Gateway C are topics for discussion with General Practice Appraisers is a positive way forward.

- North East Sector Cancer Improvement Committee Primary Care Action Plan in place which includes:
  - GP Referral Quality Programme
  - Referral Demand
  - DNA Rates
  - GP Education
  - Direct Access (DA) Diagnostics
  - Pathway Specific Projects

- Cancer Practice Champion scheme in place in some localities – Oldham, T&G, Stockport. Wigan locality have cancer champion roles in care homes.

- Specific request from Oldham locality to present the findings of the locality visits with regard to primary care funding of Gateway C – what are the different approaches / results / impact / outcomes

- Cancer Care reviews are undertaken in Salford, and recurrent commissioning of HWB co-ordinators.

- Drive in Salford to improve uptake of Gateway C through the 'Salford Standard' – a financial incentive to primary care (general practice). Also includes the NCDA. Clear communication with primary care and regular newsletters.

- GPs in Salford have a letter which they share with patients referred on a suspected cancer referral pathway (copy available if required)

- 2ww audit is imminent in Salford – across CCG and SRFT – includes a question regarding the patients' understanding of the reason for their referral

- Consistent message that strong and consistent primary care / cancer clinical leadership is a significant benefit to localities

Workforce

As noted in the main body of the report, the issues relating to workforce are similar across GM. GM Cancer asked to consider GM-wide employment models to resolve some of the workforce issues.

Key issues are: diagnostics; radiology in general – recruitment challenges; pathology – recruitment challenges; General Practice, varies across GM but concern re Practice Nurse workforce; CNS (retirement issues)

Pennine Acute reported recruitment to a significant number of navigator posts, plus MDT coordinators and trackers. The roles are relatively new so have not been fully evaluated, but there is evidence of the roles making quality improvements to patient experience.

Impact of HMRC on recruitment and retention, and delivery of additional clinical capacity noted as a GM wide issue.

It was reported that trusts who do not undertake specialist treatments, diagnostics and / or research can have greater recruitment and retention challenges than those where this IS undertaken.

Other Issues

Patient Experience: The Wigan locality reported that their meetings all start with a patient story, which is not always a story that describes a positive experience

Lymphoedema: Expansion to the service in HMR on approval of a business case to provide a service for cancer and non-cancer patients

Specialist Palliative Care: Approach to SPC and 7 day working across NES – EOLC Partnership

High Quality Services: Specific request from localities to consider quality services and not just focus on new developments, transformation, and delivery of waiting time standards.

Bury CCG held a Governing Body workshop on Cancer, with attendance from senior representatives from Pennine Acute Hospitals NHS Trust, at which issues across cancer pathways, from prevention to treatment, were discussed in detail – report made available to GM Cancer.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number **4**

Greater Manchester **Cancer**

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	22nd July 2019	
Title of paper:	**Greater Manchester Cancer Pathway Board Leadership update**	
Purpose of the paper:	To update the GM Cancer Board on the changes surrounding the leadership of the pathway boards	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	✓	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient experience and outcomes	The primary responsibility of the pathway boards is to improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire. This approach ensures there is focus on reducing inequality and addressing variation across the system. This paper will aim to update the board on how the leadership review of the pathway boards will maximise effectiveness.	
Reducing inequality		
Minimising variation		
Operational / financial efficiency	Making improvements in cancer outcomes will support the delivery of the financial and operational efficiencies described in the GM Cancer Plan.	
Author of paper and contact details	**Name:** Dave Shackley **Title:** Director, Greater Manchester Cancer **Email:** david.shackley@srft.nhs.uk	

Greater Manchester Cancer

Greater Manchester Cancer Board

Date: 22nd July 2019

Title: Greater Manchester Cancer Pathway Board Leadership update

From: Dave Shackley, Director, Greater Manchester Cancer

7 Background and Context

Historically, the pathway boards and associated projects were originally Greater Manchester Cancer's main area of activity, however since 2015, and following developments through co-leadership of the National Cancer Vanguard, Greater Manchester Devolution and more latterly, the award of £10 million GM Transformation Funding, a considerable portion of GM Cancer's activity is occurring outside the traditional pathway boards (though these projects have usually involved the pathway boards in some capacity).

As the pathway boards remain the clinical voice of the alliance, and in light of demands as set out in the NHS Long term plan reinforcing the need for clear system-wide clinical leadership, it is vital that the clinical boards continue to be highly relevant and at the forefront of GM Cancer's enterprise.

The pathway board clinical leadership(s) has in many cases remained unchanged since inception in 2014 and it is appropriate now to consider how best they can be reformed to meet the current challenges, and add extra focus and energy.

8 Leadership review

In May 2019, a session was facilitated with the Pathway Directors and Pathway Managers in attendance to discuss various elements of the pathway boards including such questions as: Should the Pathway Director posts be open to competitive challenge to add new energy? Should there be a term limit? Does the remit/ name of the Pathway Director needed to change? What works well/ needs review?

A clear consensus was reached on many points in the discussions with the following being proposed:

- A **3 year term** for the Pathway Director role, renewable at the end of that period **subject to 'open' competition/re-interview against peers**. An advertised open appointments process to be put in place at the 3 year point.
- No maximum number of terms that a Pathway Director can serve.
- All Pathway Directors will have an **annual review** and this will be the case for all, including those in post less than 3 years. As now, this will be via a **formal panel interview process, including professionals and patients**, with a summary position paper tabled at the GM Cancer Board.
- Autumn 2019 will see the recruitment for Pathway Directors in post in excess of 3 years begin.

- Any Pathway Directors at or beyond three years are free to step down should they wish.
- The **post title will change** to '***Greater Manchester Clinical Lead for …….***' (e.g. GM Clinical Lead for Gynaecological Cancer; or GM Clinical Lead for Acute Oncology etc.) *rather than* 'Pathway Director' to more simply reflect the importance and remit of the role. The post remains the same in scope, being the clinical lead for all elements of the pathway in a specific cancer area.
- In advance of autumn 2019, all Pathway Directors will receive a letter informing them of whether they need to reapply should they so wish or invited to attend their annual review, dependant on their time in post.
- The Pathway Managers will continue to support their specific pathways so as to maintain expertise/contacts.
- Pathway Directors to be encouraged to have a deputy, and or other clinicians to lead specific pieces of work on behalf of the pathway boards

Moving forward, it is the intention to ensure that **each board has its own co-produced strategy and plan**, with risks/deliverables and objectives articulated.

To help facilitate this, a series of formal and informal sessions have been scheduled to allow more support and focus for the pathway boards, to clarify ambition and provide assurance, and to provide a forum to share and challenge each other whilst giving an opportunity to showcase the excellent work that is developing out of many groups.

The Pathway Managers have been asked to present at the GM Cancer Assurance Group meetings and any ad-hoc 'hot topics' of major impact will be included on the agenda of the Senior Management Team fortnightly meetings. This will sit alongside the impending recruitment/reappointment process and annual appraisals.

Due to the length of time the existing Pathway Directors have been in post, **ten Pathway Director positions will go out to advert** in autumn 2019, with the remaining nine being subject to annual appraisal. It is unclear how many incumbent Directors will re-apply – many of these have already delivered substantial pieces of work previously and may feel they have the energy and ideas to continue. It is envisaged that re-appointment will happen in several cases, though this remains subject to open competition and the strength of both theirs and others applications.

Due to the current vacancy, this process begins with the **Clinical Lead for Breast Cancer position, with interviews having been scheduled for 30th July 2019**. The remainder of the recruitment and appraisal will follow.
It is recommended that the **long standing funding arrangements of the Pathway Director remain unchanged** [1 x PA, or equivalent] and that this continues to be **split equally** between GM Cancer and the Pathway Director's host Trust (0.5PA each).

9 Recommendation to Cancer Board

The Cancer Board is asked to note the content of this report and support the proposals outlined.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Paper number 5

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	22nd July 2019	
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 in delivery of the GM Cancer led Transformation Funded projects.	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	☐	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient experience and outcomes **Reducing inequality** **Minimising variation**	All transformation projects aim to improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire. There are outcomes measures to capture benefits, associated with each project. Due consideration has been given to minimising variation and reducing inequality through the equality impact assessment associated with each project.	
Operational / financial efficiency	Making improvements in cancer outcomes will support the delivery of the financial and operational efficiencies described in the GM Cancer Plan.	
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
July 2019

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

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 inaugural Optimal Diagnostic Sub Group was held on the 24th May 2019. The meeting was extremely well attended and outcomes achieved. The group will meet next on the 23rd September 2019.
- Sector / provider proposals for resources to support the delivery of the Best Timed Optimal Lung Pathway have been received.
- Each proposal was reviewed on the 17th June 2019. This information has subsequently been collated into a document which has been shared with the Sub Group/ Steering Group for accuracy and support.
- Current proposals are due to be shared with the Commissioning Leads group prior to submission to the GMC Assurance Group for ratification.
- Once the ratification of proposals is agreed, all providers and commissioners will be communicated with enabling the appropriate action and recruitment to posts to commence.
- Work has commenced with service users to identify and collate information supporting both survey questionnaires and qualitative feedback to support the outcomes of the project.
- Work is being progressed with the CIS team to identify and agree the capacity necessary to support the development and delivery of dashboards to assist in the projects performance management.
- Ongoing stakeholder engagement with providers and commissioners.
- Presentations have been delivered during June 2019 regarding the BTP Lung Projects progress to date at the Head and Neck Pathway Board and the GM Cancer Lung Education & Engagement event.

Measures of Success

- To agree and implement new pathways that ensure our patients begin their treatment within the current standard of 62 days
- Through a stepped approach increase the proportion of patients given definitive cancer

diagnosis, or all clear within 28 days of referral by a GP to 95% by 2020

- Referral to treatment reduced to 28 days by 2021
- Ensure that dedicated patient feedback and surveys support pathway design and patient satisfaction

Project:	**Accelerated Pathways: Prostate**
GM Cancer Leads:	Satish Maddineni – Clinical Lead Susan Todd – Project Manager Fiona Lewis – Pathway Manager: Urology

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 project aims to support all stakeholder Trusts within GM and East Cheshire to implement the new diagnostic pathway undertaking high quality mpMRI prior to prostate biopsy and clinical review. The project will seek to establish a number of urology hubs (most likely one in each of the existing 4 GM urology sectors) to manage new suspected prostate cancer referrals across provider Trusts within each sector to support each patient and give equal patient access to specialist prostate cancer diagnosticians/clinicians, minimising patient travel and morbidity where possible.

Progress and Roll Out Proposals

Each sector/hub will require pathway navigators and/or clinical nurse specialists depending on how each sector's urology service functions operationally with the Trusts/hospital sites. These posts are to facilitate the timely management of the patient journeys including appropriate clinical triage into the pathway and communication with the patient along the pathway. Transformation Funding will facilitate the delivery of this project up to 31/3/2021. The evaluation of the project will support the production of a business case to feed into the appropriate fora where stakeholders can consider the costs, financial benefits and patient benefits of the project and thereby take an informed view as to whether the transformation funded phase of the project justifies its mainstreaming into business as usual. Metrics have been carefully chosen to ensure the impact of projects can be measured as the project is rolled out across GM.

The recruitment process for the first pathway navigator post, based at Salford Royal NHS Trust, has begun.

Progress to date includes:

- Sector and Trusts specific requirements to facilitate alignment with the prostate best timed pathway and 28 day FDS under final review to ensure best fit for posts to maximise outcome measures
- Service specification for CCG's in draft
- Second steering group meeting held 27/6/19

- Work streams identified – Radiology and data collection prioritised
- Primary care engagement begun at Urology event in June – patient information and referral information discussed
- First transperineal prostate biopsies performed under local rather than general anaesthetic performed in outpatient clinic setting in the North West in June, reduces time on the pathway and sepsis/infection risk as transperineal rather than transrectal approach.

Measures of Success

The key measures of success are:

- Compliance with the Faster Diagnosis Standard (28d) by end March 2020 (NHSE threshold to be confirmed)
- More than 90% of suspected prostate cancer patients rating their diagnostic pathway as very good by end March 2021 (scale for patient experience survey to be confirmed)
- More than 90% of magnetic resonance imaging (MRI) suitable new suspected prostate cancer patients to have mpMRI scan by day 7 of the pathway by end March 2021
- 25% relative reduction in the number of prostate patients having biopsies by end March 2021
- More than 90% of patients with prostate cancer confirmed by biopsy to be discussed in specialised MDT by day 21 by end March 2021.

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

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. The NHS planning guidance for 2019-20 includes the following statement:

“All providers must start to collect the 28-day Faster Diagnosis Standard data items in 2019/20, in preparation for the introduction of the Standard in 2020. Organisations, working through their Alliances, should use the data items to improve time to diagnosis, in particular for lung, prostate and colorectal cancers.”

Meanwhile the number of colorectal urgent referrals continues to increase significantly year on year. Access to timely and effective cancer services is crucial for patient experience and outcomes.

The graph below shows the 62 day standard of 85% for the financial year 2018/2019, including all providers across Greater Manchester.

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, reducing the time to a diagnosis and ultimately treatment. Currently across GM there are a range of different approaches to establishing a colorectal best timed pathway. This includes virtual triage (via a consultant triaging based on the information received from primary care), consultant telephone triage, pre-op led triage and assessment and traditional pathways including no straight to test element.

The project therefore looks to work with Trusts in relation to their pathways, or support Trusts to implement best timed pathways where they do not exist. Funding will cover the costs of specialist nurses to lead new telephone assessment and triage systems to facilitate STT and Cancer Navigator roles to support patients and streamline the pathway. The project aims to ensure that whatever area a patient is from, they experience the same level of care and have the same chance of receiving a definitive yes/no cancer diagnosis no longer than 28 days after urgent referral.

We will also be putting processes in place to audit primary care urgent referrals and regularly share the results of these audits with GP practices. We will engage further with GP practices as required to support best practice in relation to urgent referrals.

Progress and Roll Out Proposals

Transformation Funding will facilitate the delivery of this project up to 2020-21 (with funded roles being supported up until end of March 2021), which includes the delivery of a key component of national planning guidance and working towards achieving the incoming 28 day standard. The evaluation of the project will support the production of a business case through which the costs, financial benefits and patient benefits can be considered for mainstreaming into business as usual from end of March 2021. Metrics will be carefully chosen to ensure that the impact of projects can be measured as the project is rolled out across GM. Key milestones include:

- End of June – After engaging with Trusts, all proposals have been receiving detailing the proposed changed each Trust intends to make to their pathways and the resources needed to facilitate these changes

- July 11th – Colorectal Best Timed Pathway Steering Group to agree proposal for GM wide funding allocation

- Mid July – GM Cancer Project Assurance Group confirms allocation of funding and decision is

communicated with Trusts and commissioners

- August – Implementation stage begins; recruitment process begins in Trusts for new CNS and Navigator roles

Measures of Success

All outcome measures focus on the first 28 days of the pathway. Any potential changes or improvements beyond the first 28 days of the pathway are outside of the scope of the project. However, it is anticipated that the project will have significantly positive contributions to meeting 62 day targets by improving the early stages of the pathway up until communication of a cancer diagnosis / all clear with the patient.

The GM-wide outcome measures are subject to change due to the national FDS target for 28 day not yet being confirmed and are shown below. Once the national FDS targets are released these outcome measures will be updated.

Primary outcome measures	Day on pathway	Key milestones	Date
1. Achieve Faster Diagnosis Standard (28d) by March 2020 (*Once the national standard % for FDS is released, this and all other outcomes measures will be updated accordingly)	**Across full 28 days of pathway**	Achieve Faster diagnosis standard (28d) aggregated across GM	Mar-20
		Achieve Faster diagnosis standard (28d) in 75% of all Trusts	Sep-20
		Achieve Faster diagnosis standard (28d) in 100% of all Trusts	Mar-21
2. >TBC% patients have telephone assessment and triage by day 3 by March 2021	**3**	**>TBC% patient**s have telephone assessment and triage by day 3	Mar-20
		>TBC% patients have telephone assessment and triage by day 3	Sep-20
		>TBC% patients have telephone assessment and triage by day 3	Mar-21
3. >TBC% patients have either telephone triage and STT referral OR telephone triage and first OPA by day 7 of pathway by March 2021	**7**	**>TBC% patients** have either telephone triage and STT referral OR telephone triage and first OPA by day 7 of pathway	Mar-20
		>TBC% patients have either telephone triage and STT referral OR telephone triage and first OPA by day 7 of pathway	Sep-20

		>TBC% patients have either telephone triage and STT referral OR telephone triage and first OPA by day 7 of pathway	Mar-21
4. >TBC% patients have endoscopy / first investigation by day 14 by March 2021	**14**	**>TBC% patients** have endoscopy or alternative by day 14	Mar-20
		>TBC% patients have endoscopy or alternative by day 14	Sep-20
		>TBC% patients have endoscopy or alternative by day 14	Mar-21
5. >TBC% patients discussed in MDT by Day 21 by March 2021	**21**	**>TBC% patients** discussed in MDT by Day 21 by March 2021	Mar-20
		>TBC% patients discussed in MDT by Day 21 by March 2021	Sep-20
		>TBC% patients discussed in MDT by Day 21 by March 2021	Mar-21

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. This builds on the success of ERAS+ (Enhanced Recovery After Surgery+), the in-hospital offer to surgical patients across Greater Manchester. 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.

GM Active, representing all twelve leisure and cultural organisations operating local authority owned leisure and cultural assets across Greater Manchester, are GM Cancer's delivery partners and offer this programme in leisure facilities local to participants place of residence for improved accessibility and long-term behavioural change. The fitness instructors delivering the programme all have cancer rehabilitation qualifications. Learning has been gained from CAN-move, the commissioned Salford-based cancer exercise referral scheme which has been benefitting Salford patients over the last 3 years.

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.

Progress and Roll Out Proposals

This programme launched on the 25th April 2019 and has received 166 referrals within the first 8 weeks, with only 12 people referred not taking up the offer (92% uptake rate). These referrals have come from across GM hospital sites and across the eligible tumour pathways which includes colorectal, lung and upper GI cancers. At present patients who are being considered for curative major surgery are able to be offered this programme. Roll out has been successfully delivered through stakeholder engagement via the relevant tumour specific pathway boards (Colorectal, Lung and Oesphago-Gastric) with monthly pathway-specific subgroup meetings to support safe delivery of the programme for patients. The project links closely to ERAS+, the in-hospital element of preparation for surgery, infrastructure that already exists across many of the hospital sites in GM.

The programme's performance review and implementation group meet bi-monthly. Data from the first meeting demonstrated positive patient experience and feedback from those participating so far. Half the participants were stratified into our targeted, supervised pathways based on initial physiological, nutritional and wellbeing screening with the other half receiving our universal offer. Of the participants engaged in the structured, targeted pathway the majority were achieving almost 3x a week exercise sessions of the recommended exercise dose (graded to the individual). 100% of patients do not need to travel further than five miles to access the programme, 100% of patients are being contacted by the core GM Active Prehab4Cancer team within 48 hours of referral and 82% are being seen face to face within 4 days of referral.

In the second phase of the project the programme will be extended to people within the tumour groups already identified, being treated primarily with chemotherapy and radiotherapy as learning is understood from participants within phase 1, undergoing neoadjuvant chemotherapy prior to major surgery. Eligibility criteria in the second phase will also include people diagnosed with Head and Neck cancer (surgery type and radical treatment to be determined). We aim to launch phase 2 in November 2019. Scoping and preparation to support this launch is taking place from June 2019 to October 2019, including forming expert subgroups to support delivery of prehabilitation for patients undergoing radical oncological treatments and introducing dynamic testing (CPET + other functional tests) to a proportion of these patients to understand their baseline fitness and function prior to, during and after treatment.

Further roll out includes procurement of wearable devices, a prehab4cancer website, a generic prehab4cancer preparatory information leaflet aimed at anyone with cancer living in Greater Manchester and a digital platform to support maximised participation, improved participant benefits, the universal offer being able to be scaled to larger numbers of patients and evaluation of the programme. We are also planning an education event called 'Fitness for Cancer Treatment: Fitness for Life' for approximately 200 delegates (including MDT healthcare professionals, researchers, GM Active fitness instructors and people affected by cancer) in September 2019. This day will provide further information on the rationale, evidence base and implementation of multi-modal prehabilitation (exercise, nutrition and psychological wellbeing) and ERAS+, enabling attendees to be able to confidently provide consistent advice to people diagnosed with cancer on how they can best prepare themselves prior to and during cancer treatments and for optimal recovery.

Measures of Success

- High uptake of the programme, close to 2000 people participating in the programme across Greater Manchester over 2 years,
- 90 day hospital free period, 1 year and 2 year survival,
- Reduced post-treatment complications and resulting resource use (health and social care – in secondary and primary settings i.e. reduced hospital admissions, complex long GP appts etc),
- Improved continuation with and tolerance to treatment – particularly for patients undergoing chemotherapy and radiotherapy,

- Improved QOL PROMS + PREMs (EQ5D, FACT subsets, WHO-DAS etc.).

Project:	**Recovery Package**
GM Cancer Leads:	Wendy Makin – Clinical Lead Lindsey Wilby – Project Manager

Summary of Project

The Recovery Package is a combination of Personalised Care Interventions that, when delivered together, can greatly improve the outcomes and coordination of care. The interventions are:

- (electronic) holistic needs assessment (eHNA) leading to the production of a care plan
- treatment summary
- cancer care review
- health and wellbeing information and support

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

The transformation funding allocated to this project will be used to accelerate the implementation of the Recovery Package Personalised Care Interventions by employing a total of 10 Cancer Support Workers across selected Trusts for a period of up to 18 months (to 31st March 2021).

The role of the Cancer Support Worker involves supporting and co-ordinating the pathway for patients living with and beyond a diagnosis of cancer, and implementing those elements of the Recovery Package which are described in the NHS Long Term Plan (described as personalised care for cancer patients) – thus fulfilling both regional and national objectives. We will be testing several delivery models, with a plan to develop a compelling business case for system leaders to consider for future roll out across the region.

The chosen sites are Tameside & Glossop and Stockport (joint approach), and The Christie (including Salford and Wigan satellite sites). Recruitment of Cancer Support Workers is currently in progress, with a target for staff can be recruited and in post by 1st October 2019. Progress regarding both quantitative and qualitative outcome measures will be monitored via the GM Cancer Programme Assurance Group.

Plans for further roll out of the Recovery Package Personalised Care Interventions include a bid for additional funding to develop an online patient portal to fulfil the objective of providing a sustainable health and wellbeing offer for all patients.

Measures of Success

Quantitative: Step-change in the implementation of the elements of the Recovery Package Personalised Care Interventions within the targeted tumour groups. By the end of the project, for ALL appropriate patients:

- HNAs should be completed around the time of diagnosis and again at the end of treatment (unless

declined)

- End of treatment summaries should be provided at the end of every treatment modality
- Access to a Health and Wellbeing Event (or equivalent information and support) should be offered

Qualitative: by the end of the project, patients should report improvements in their patient experience and quality of life, as a result of the therapeutic conversations experienced, information disseminated, interventions recommended, and access to support services offered

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.

The term 'CURE' has been specifically chosen to 'medicalise' tobacco addiction and move away from the stigma of a lifestyle choice to disease treatment. Treating tobacco addiction must become part of the core activity of all clinicians in every part of the hospital.

Progress and Roll Out Proposals

The long term plan is the roll out of CURE to all hospital sites across Greater Manchester. The scope of the phase 1 Transformation Funding bid includes the costs for Wave 1 rollout of CURE to 6 hospital sites (in addition to South Manchester as the pilot site):
- Tameside & Glossop (Tameside & Glossop NHS ICFT – Tameside Hospital site)
- Bury (Fairfield Hospital, Pennine Acute Trust – Bury CCG and HMR CCG)
- Salford (Salford Royal NHS Foundation Trust)
- Oldham (Royal Oldham Hospital, Pennine Acute Trust)
- Stockport (Stepping Hill Hospital, Stockport NHS Foundation Trust)
- Wigan (Royal Albert Edward Infirmary, Wrightington, Wigan & Leigh NHS Foundation Trust)

The GMC CURE Steering Group meet in June and agreed membership, Terms of Reference and identified key elements for the group to focus on, such as evaluation that can aid in future targeted services and the importance of linking with GP's and Primary Care to build a successful engagement strategy across GM for the rollout.

Updates since the last GM Cancer Board:
Pathway mapping & gap analysis sessions have been organised and partially completed to identify how each locality will deliver the pathway aligning to the GMC CURE Service Specification.
IT identified as key enabler – focused on setting up groups in each locality to work through how data will be recorded and where
Primary Care eLearning training modules in final stages of development – content has been aligned to CURE modules ensuring consistency of message and training for clinical staff across secondary and primary care
Clinical Leads identified and met with to discuss what their role will require to ensure engagement from within their Trust from clinical staff
Worked with Kings College London on a membership/contact list that will form the basis of a Delphi study used to create a nationally recognised evaluation framework for acute care based smoking cessation models

A GM CURE Service Specification has been drafted and is due for approval via the GM CURE Steering Group before being shared with Commissioning leads across Greater Manchester, which will form the basis of the contract variations that will be used to monitor the rollout of CURE.

Measures of Success
Final metrics in development but will include smoking quit rates and impact on hospital admissions. To consider measures of wider system impact including primary care.

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 release capacity to address the expected increase in patient numbers.

Initially the project is rolling out the risk stratified follow-up pathway that was put in place at Pennine and MFT (Nightingale Centre) through the Macmillan Cancer Improvement Partnership to the remaining breast services in Greater Manchester (Tameside & Glossop, Ashton Leigh & Wigan (Wrightington Wigan & Leigh NHS FT), East Cheshire, Bolton and Stockport) to ensure standardisation of care.

The project will also be looking for a site to pilot colorectal risk stratified follow-up based on the soon to be released NICE recommendations for surveillance tests and will do initial preparation work for putting a GM-standard risk stratified pathway in place for prostate cancer. Apart from the one pilot site for colorectal cancer, the work to standardise risk stratified follow-up in colorectal and prostate cancer are reliant on a successful further bid for transformation funding.

The resources available through the current project funding are:

- An IT solution for tracking stratified follow-up patients with technical support, if required
- Aftercare Coordinators (each breast site and one colorectal site).
- Project Manager and Clinical Lead

Progress and Roll Out Proposals

Breast Risk Stratified Pathway
Initial workshops for all stakeholders in the breast pathway are now underway at the individual sites, due for completion by the end of July 19, with action plans drawn up to put the pathway in place. Band 4 Coordinator role out for advert at Tameside. Tameside have a go live date of 1/9/19.

Colorectal Risk Stratified Pathway
Scoping has identified areas of good practice where the pathway is already in place (MRT and Salford Royal) which will be used as the evidence base for roll out at the other sites. The protocol for the schedule of aftercare tests, a Cancer Alliance deliverable for 2019/20, was agreed at the meeting of the Colorectal Pathway Board on 5/7/19.

IT Solution
A workshop comprising operational leads, members of the colorectal, urology and breast clinical teams, Trust IT and Information Governance with demonstrations of the potential systems that are capable of tracking patients on a supported self-management pathway took place on 21/6/19. Feedback from this event will be used as the basis for the decision about which IT solution to use at a meeting of the project steering group on 10/7/19.

Measures of Success

Moving to this model will enable around 50-70% of breast, 50% of colorectal, and 30% of prostate patients to self-manage with support, requiring only imaging or biochemical surveillance, and patient initiated contact as required. Clinically valuable surveillance tests are uncoupled from routine

outpatient follow up appointments, and can often be carried out in community settings, reducing the amount of time patients take off work or away their preferred activities to attend appointments and providing better patient experience.	
Project:	**CAN-Guide (Supported Decision Making around Palliative Chemotherapy)**
GM Cancer Leads:	Janelle Yorke
Summary of Project	
Following a successful small Greater Manchester pilot of an enhanced-decision making package called the 'Goal 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 has begun to establish a baseline of patient involvement in Shared Decision Making prior to the first wave of implementations of GOCI. This has involved clinics within the lung, sarcoma, renal, gynaecology, and colorectal so far with more being approached to begin data collection shortly. The content for the Can-GUIDE website and accompanying booklet is being finalised based on PPI. This includes new film content and interactive resources for patients to engage with. Significant progress has been made in this area and we are now ready to begin filming content for the website. The team has also met with a graphic designer to begin finalising the booklet design prior to printing. The GOC tool has now been incorporated into the Christie's electronic patient record system. Testing has begun to ensure the tool works within the system and so far there have been no issues. Incorporating this into clinical practice will occur at the same time each of the teams receive the GOCI training. Clinician training in using Can-GUIDE will now include training using a SDM conversational framework which is being developed in conjunction with NHS England. Stakeholder focus groups are in the process of being arranged and we anticipate that the framework will be ready for the first round of implementation in November/December 2019. The adverts for the research assistant posts are out to advert now and we anticipate them being in post by the end of the summer.	
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. The project recruited the Director of Education (Catherine Heaven) in September 2018, and Education Programme Manager (Rachel Hickson) started in role in April 2019. 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

- Scoping work is drawing to a close in July, therefore deliverables are currently being looked in to in more detail, to be agreed to with the GM Cancer Education Board at the next meeting – date TBC.

- Continued facilitation and delivery of educational events that are free and accessible to the GM & EC health and social care workforce. Events this reporting period; EoL Care Workshop, Lung Event, Urology Event.

- After investigating options, a GM Cancer mailing list platform has been selected and a tailored set up has been put in place in line with our requirements. People are signing up regularly and we are already using targeted mailshots to great effect in promoting our educational events.

- Internal data sharing arrangements have been drafted with The Christie Information Governance team, which is to be approved imminently. Following this approval, Gateway C will share their GM & EC primary care contacts with GM Cancer to grow our mailing list further.

- GMCC Committee meetings continue; meetings have been separated in to a Scientific Committee to focus on content/speakers, and a Logistics Committee. There is some overlap of attendees at these meetings so that the full picture is understood at all meetings. The agenda for the two day conference has been largely set, with the themes being 'Innovation, Integration, Collaboration' and 'Personalised Care'. Speakers are being approached and invited at present, with some confirmed already. Symposium sessions are being discussed with the relevant teams. The SoO are our Secreteriat, and will be contacting potential sponsors in the coming weeks, once sponsorship packages have been finalised and agreed.

- Discussions have taken place with the Gateway C team and GM Cancer Comms team regarding a regional hub for GM, integrations and considerations. Conversations to be continued following further alignment.

Project:	**Cancer Intelligence Service**
GM Cancer Leads:	Catherine O'Hara – Principal Analyst

Summary of Project

This project offers Greater Manchester Cancer (GMC) a dedicated cancer intelligence service superior to anything found in any other Cancer Alliance. A service that can deliver an innovative solution and remains agile and responsive to the evolving data and intelligence needs of the GMC System and H&SCP, including people affected by cancer, offering analytical and statistical resources dedicated to the transformation projects and above all, offering access to timely metrics fed from local data flows within an interactive dashboard application. This will provide partners in the cancer system, including service users, with access to the most current and detailed performance, outcomes and patient experience data available

GMC is the first Vanguard/Alliance to:

- have its own cancer intelligence portal with interactive dashboard functionality that is specifically designed for the GMC System.
- have cancer intelligence dashboards designed by and for people in GM affected by cancer.
- use locally collected data to create a locally collated data set that will generate intelligence that is in sync with current cancer activity.

Having a centralised local cancer intelligence service ensures the GMC System has the data, intelligence and tools it needs to help deliver the GM Cancer Plan and:

- Provide GMC System wide monitoring of service performance, clinical outcomes and experience for patients
- Utilise local data flows to provide access to data and metric measures that reflect current service and clinical activity
- Be a centralised analytical resource to examine the story behind cancer services metrics; identify best and worst performers, investigate reasons for variation, measure trends, and provide narrative to help interpretation and dissemination.
- Be a centralised analytical resource to support all Transformation projects, reducing the individual financial and resource burden for each project regarding collation, analysis and reporting of data.
- Empower CCGs and Providers to get maximum benefit from their own data, identify areas in need of improvement and drive transformation.
- Compare and benchmark against similar services and performance in other geographical areas.
- Empower patients to make decisions around their own care based on intelligence.

Progress and Roll Out Proposals

- The CIS team attended the GM BI Leads Group meeting to present on progress which included in-depth discussion around further collaborative working. Follow up meeting has been scheduled with HSCP BI lead for July.
- Second data meeting with the core team demonstrated a new dashboard and highlighted trends and patterns around early and late stage diagnosis. The next meeting in September will focus on patient experience reporting.
- Work is almost complete on evaluating the quality of cancer waits data to measure 28 days and breach allocation based on inter provider transfer dates and will be ready to share initially with Cancer Managers for discussion and input in August.
- A report on new ways to look at 62 day pathway timings is also in development and will be shared initially with the Pathway Leads and Managers for comment in August.
- Second phase of the GM CIS Portal is now underway – this will include a new dashboard on patient experience reporting as well the introduction of more SPC charts for metric reporting and standardisation of formatting and visualisation across all dashboards. This will involve collaboration and consultation with all current Portal users and other stakeholders including

GM BI leads and analysts and is expected to be complete in October.

- Continued benchmarking of our system/alliance against other alliances and England average for key metrics.
- Project specific support continues to be provided on request to all TF1 and pathway projects facilitating access to data, developing bespoke dashboards, attending pathway board meetings and undertaking evaluation analyses. Advice on analytical components of TF2 projects has also been provided.
- A lunch and learn session is being planned on Statistical Processing Charts (SPC) as a method for service assurance as well as project evaluation.
- Work is ongoing with the CURE project team, facilitating access to data, helping to set up data sharing agreements and a process for accessing their data for evaluation.
- Work is ongoing with the Prehab4Cancer team helping to identify new data sources for their evaluation and co-ordinating meetings between Prehab and DSCRO to identify processes for accessing these data.
- Meeting held with Pfizer to advise on availability of data to support project around secondary breast cancers.
- Local data flows development work is underway with 4 Providers data already being processed. The Data Sharing Agreement is currently being renewed and we have taken this opportunity to add additional national and local data sets which will substantially broaden the potential for analyses and reporting.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Paper number 6

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	22nd July 2019	
Title of paper:	**GM Cancer Risk Register**	
Purpose of the paper:	The purpose of the paper is to provide members of the GM Cancer Board with oversight of the overarching GM Cancer risks.	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	✓	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient experience and outcomes	The paper documents risks associated with the delivery of improved patient outcomes and experience alongside the responsibility of not discriminating on the basis of the GM Cancer 'protected characteristic' groups. Mitigations ae noted to minimise system variation also.	
Reducing inequality		
Minimising variation		
Operational / financial efficiency	The risk register captures the operational and financial risks with actions and mitigations documented	
Author of paper and contact details	**Name:** Alison Armstrong **Title:** Programme Lead, Greater Manchester Cancer **Email:** alison.armstrong7@nhs.net	

Greater Manchester Cancer

Risk Register July 2019

ID	Date Raised	Risk Description	Owner	Likelihood	Impact	Score		Proximity	Further Action Planned.	Likelihood	Impact	Score	Last reviewed
A unique coding that allows the risk to be easily identified		A statement describing the risk event, cause and impact	Job title of the person responsible for the management, monitoring, control and escalation where appropriate, of the identified risk	Current			Trend	Timescale as to when the risk will occur	(Who, What, Why and when anything more will be done to reduce the residual risk)	Mitigated			Last reviewed
1	04/07/17	Inability to deliver the cancer waiting times. If the system does not improve timely access to its services then the 62 day cancer waiting time standard will continue not to be met. Timely diagnosis and treatment are key to delivering better patient outcomes.	Cancer SRO	4	5	20	↔	0-3 mths	A Programme Director has been appointed to deliver the action plan: •GM cancer team and SLT have identified Trusts/ Providers that are not achieving required standards and are actively managing recovery plans as part of quality and assurance board at GM H&SCP. • Ensure adherence to 62 standard report monitored monthly through director of Operations group (and quarterly at the Trust cancer leads meeting) and reporting to the GM Cancer board. •Providers who consistently have not achieved the standard are now under 8 week review processes by GM HSCP Performance and delivery Board via the GM Cancer Board. • Cancer intelligence (CI) unit monthly reporting by dashboard on performance • Programme of work in place to deliver pathway level improvement to ensure delivery against national targets • Implementation of best practice pathways in key pathways –lung, colorectal and prostate •Commenced MDT clinically led review and reform in Gynae and	2	5	10	01/07/19

						16	↔		Head& Neck pathways			12	
2	04/07/17	There is not sufficient workforce capacity in the system to support the level of ambition proposed in the cancer plan. The need to diagnose more cancers and earlier is placing additional demand on the workforce.	Cancer SRO	4	4	16	↔	3-6 months	• Monitor progress against workforce Gap analysis March 2018 with HEE and alliance leads and HR directors • GM Cancer Workforce Lead appointed and will take up post in August 19. •Continue to engage with all Pathway boards to understand the workforce issues •Review and application of Macmillan and CRUK reports on Cancer workforce and the NHS People Plan • Workforce planning-connected with HEE in 7 key priority areas- awaiting funding agreement on this.	3	4	12	01/07/19
3	04/07/17	Insufficient capacity to diagnose, treat and follow up patients in a timely manner.	Cancer SRO	3	4	12	↔		• GM Cancer Associate Commissioner to manage capacity and demand modelling and review to ensure sufficient commissioned activity and capacity-working with providers who currently do not have sufficient capacity • Pathway redesign & accelerated pathway- new diagnostic models and stratified follow ups/ recovery package/ERAS+-funding now underway as part of the priority 1 projects • Capacity planning linked to resilience plans regarding non elective admissions, delayed discharges and re-admissions and access to underutilised hospice activity	2	4	8	01/07/19

4	04/07/17	There is a risk that GM will not **achieve** the cancer programme aims identified in the GM cancer plan and the NHS Long Term Plan due to financial uncertainty of funds being routed to GM Cancer	GM Cancer Director of Finance	3	4	12	↔	3-6 months	• Delivery of priority 1 projects will be reported to GM cancer board and fortnightly to the GM Cancer team business meetings to monitor progress against the milestones and objectives detailed within the GM Cancer Plan and take action where there are risks to delivery • Agree appropriate hosting arrangements with the Christie for financial and budget control and financial planning. • Any risks to delivery will be escalated at GM cancer SMT meeting (twice monthly) and through GM cancer board and highlighted to DOF's as and when necessary. •Monthly assurance meeting and review within GM Cancer by Associate Finance Director	2	4	8	01/07/19
5	04/07/17	There is a risk that GM will not sustain programme aims identified in the GM cancer plan and the NHS Long Term Plan due to financial uncertainty of funds being routed to GM Cancer and ongoing commitment from the responsible commissioners	GM Cancer Director of Commissioning	3	4	12	↔	12 months +	• Delivery of priority 1 projects will be reported to GM cancer board and fortnightly to the GM Cancer team business meetings to monitor progress against the milestones and objectives detailed within the GM Cancer Plan and take action where there are risks to delivery • Appropriate hosting arrangements with the Christie for financial and budget control and financial planning agreed. • Any risks to delivery will be escalated at GM cancer SMT meeting (twice monthly) and through GM cancer board and highlighted to DOF's as and when necessary. •Monthly assurance meeting and review within GM Cancer by Associate Finance Director • Agreed priority areas for funding •Projected agreed from transformation funding agreed in June 18 are underway . •Fortnightly GM Cancer team business meetings to monitor progress against the milestones and objectives detailed within the GM Cancer Plan and take action where there are risks to delivery. • Long term plan for priority 2 projects funding requirements of the cancer plan delivery developed •Ongoing engagement of commissioners to ensure robust evaluation undertaken and sufficient information shared to enable an informed decision to be taken regarding future funding beyond TF	2	4	8	01/07/19

6	01/06/19	Lack of defined resource to implement priorities e.g. genomics and radiotherapy networks	Cancer SRO	4	3	12	↔	3-6 months	• Genomics Project Manager and Clinical Lead funded 'at risk' • Close working relationships with The Christie to progress the radiotherapy networks piece of work • positive discussions regarding further funding for cancer programmes with The Partnership •A series of proposals has been developed for when further funding is secured to progress priorities		2	3	01/07/19
7	01/06/19	Insufficient depth of data analysis/evaluation to track progress and inform real time prioritisation of resource	GM Cancer Associate Director	3	4	12	↔	3-6 months	• The Cancer Intelligence Service (CIS) team attended the GM BI Leads Group meeting to present on progress which included in-depth discussion around further collaborative working. Follow up meeting has been scheduled with HSCP BI lead for July. • Second data meeting with the core team demonstrated a new dashboard and highlighted trends and patterns around early and late stage diagnosis. The next meeting in September will focus on patient experience reporting. • Work is almost complete on evaluating the quality of cancer waits data to measure 28 days and breach allocation based on inter provider transfer dates and will be ready to share initially with Cancer Managers for discussion and input in August. • A report on new ways to look at 62 day pathway timings is also in development and will be shared initially with the Pathway Leads and Managers for comment in August. • Second phase of the GM CIS Portal is now underway – this will include a new dashboard on patient experience reporting as well the introduction of more SPC charts for metric reporting and standardisation of formatting and visualisation across all dashboards.. This will involve collaboration and consultation with all current Portal users and other stakeholders including GM BI leads and analysts and is expected to be complete in October. • Continued benchmarking of our system/alliance against other alliances and England average for key metrics. • Project specific support continues to be provided on request to all TF1 and pathway projects facilitating access to data, developing bespoke dashboards, attending pathway board meetings and undertaking evaluation analyses. Advice on analytical components of TF2 projects has also been provided. Local data flows development work	2	4	8	01/07/19

									is underway with 4 Providers data already being processed. The Data Sharing Agreement is currently being renewed and we have taken this opportunity to add additional national and local data sets which will substantially broaden the potential for analyses and reporting				
8	01/06/19	Prioritising the cancer waiting time performance has the potential to detract from delivery of the transformation projects and work of the pathway boards	GM Cancer Programme Lead	3	4	12	↔	3-6 mths	• Dedicated resource identified in the newly appointed Programme Director to lead the CWT action plan • Programme Lead and Associate Director of Commissioning supporting the Project Managers and Pathway Boards in delivery. • TF funding agreed so far will only allow for the funding plans agreed in priority 1 projects. Funding for the priority 2 projects funding requirements of the cancer plan delivery to be addressed in the next 6 months •This will be monitored through the GM Cancer SMT and oversight group, with support from the recently recruited Programme support officer •A programme of meetings with localities is being undertaken to develop the sustainability plans of the programme of work across GM	2	4	8	01/07/19

9	01/06/19	Failure to deliver the project activities in a way which does not discriminate on the basis of the GM Cancer 'protected characteristic' groups leading to is a risk of reputational damage due to the underlying aim to minimise variation and reduce inequality	GM Cancer Associate Director of Commissioning	2	4	8	↔	12 months +	• TF projects each have an Equality impact assessment completed. • TF projects are proof of concept prior to being rolled out across all disease groups/localities subject to evaluation and sustainable modelling • TF2 funding proposals submitted to allow any roll out required •A programme of meetings with localities has been undertaken to develop the sustainability plans of the programme of work across GM •User involvement integrated in all aspects of GM Cancer including GM Cancer Board and TF project steering groups to advise and direct	1	4	4	01/07/19
10	04/07/17	Failure to provide sufficient information and evidence of evaluation to allow localities to make an informed decision regarding future funding arrangements beyond the end of the project	GM Cancer Director of Commissioning	2	4	8	↔	12 months +	• Plans developed to identify, track and monitor benefits realisation now in place. • Metrics identified within the cancer plan and reported to GM performance board/ GM cancer board • TF funding agreed so far will only allow for the funding plans agreed in priority 1 projects. Funding for the priority 2 projects funding requirements of the cancer plan delivery to be addressed however proposals have been developed •This will be monitored through the GM Cancer SMT and oversight group via the Programme support officer •A programme of meetings with localities has been undertaken to develop the sustainability plans of the programme of work across GM • Ensure full evaluation of the projects, with clear outcomes and measurable benefits, and engagement of appropriate commissioners from the outset, thus providing sufficient information and assurance to enable an informed decision to be taken. Use standard NHS contracting mechanisms where appropriate to support the transaction of TF to localities.	1	4	4	01/07/19

Key

Likelihood

1 **Very low:** Only occurs in exceptional circumstances.

2 **Unlikely:** Expected to occur in a few circumstances.

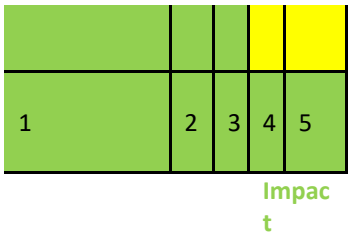
3 **Possible:** Expected to occur in some circumstances.

4 **Likely:** Expected to

5	10	15	20	25
4	8	12	16	20
3	6	9	12	15
2	4	6	8	10

occur in many circumstances.

5 **Almost certainly:** Expected to occur frequently.



Impact

1 **Negligible:** No noticeable impact on day-to-day operations. No impact on reputation / no media interest. Complaints unlikely.

2 **Minor:** May have a slight impact on day-to-day operations but can be easily resolved**.** Slight impact on reputation with some localised, low level negative impact. Low level of complaints.

3 **Moderate:** Some disruption to day-to-day operations requiring management discussion / intervention. Potential for adverse publicity but of limited scope and duration that can be managed. Generates a limited number of complaints.

4 **Major:** Disruption of day to day operations requiring executive input and notification to the Board. Adverse publicity including some national press. High number of complaints. Could impact on ability to influence.

5 **Catastrophic:** Day to day operations disrupted for prolonged period**.** Wide loss of supporter / beneficiary confidence. Major and widespread adverse publicity.

Proximity

As well as measuring the likelihood and the impact of a risk, it is important to assess its proximity, i.e. when the risk is likely to occur:

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Paper number 7

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	22nd July 2019	
Title of paper:	Rapid Diagnostic Centre's: Next Steps for Greater Manchester Cancer Alliance 2019 - 2020	
Purpose of the paper:	To update the Greater Manchester Cancer Board on the proposed process for the implementation of Rapid Diagnostic Centres (RDC's) in Greater Manchester (GM).	
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 a proposed process for the implementation of RDC's in Greater Manchester to support earlier and faster cancer diagnosis by assessing patients' symptoms holistically and providing a tailored pathway of clinically relevant diagnostic tests as quickly as possible. With the key aim to improve outcomes, patient experience and reduction in variation across Greater Manchester.	
Improved patient experience	Improving outcomes, access and reducing variation are two key factors in patient experience, addressed by providing a series of coordinated tests and a single point of contact, through the development of an RDC approach.	
Reducing inequality	The delivery of the Greater Manchester Cancer Plan is heavily predicated on demonstrating a reduction in inequality across the system.	
Minimising variation	Reducing unwarranted variation in referral for, access to and in the reliability of relevant diagnostic testing by setting national standards for RDC's.	
Operational / financial efficiency	To create increased capacity through more efficient diagnostic pathways by reducing unnecessary appointments and tests.	
Author of paper and contact details	**Name: Sue Sykes** **Title:** Senior Programme Manager, Greater Manchester Cancer Services, GM Joint Commissioning Team **Email:** susansykes@nhs.net	

Greater Manchester Cancer

Date: 22nd July 2019
Title: Rapid Diagnostic Centre's: Next Steps for Greater Manchester Cancer Alliance 2019 - 2020
From: Sue Sykes Senior Programme Manager, Greater Manchester Cancer Services and Dr Sarah Taylor, CRUK GP Cancer Lead, Greater Manchester Cancer Services.

1. Context

NHSE and NHS Improvements Draft Rapid Diagnostic Centre: Vision and 2019/10 Implementation Specification (June 2019) produced to enable a consistent and equitable approach to the development of RDC's across England:

- Outlines the draft vision for how RDC's will, over time, transform cancer diagnostic services.
- Provides a specification for Cancer Alliances to begin setting up RDC's in 2019/20.

The commitment to roll out Rapid Diagnostic Centres (RDC's) in England forms an important part of NHSE's wider strategy for delivering faster and earlier diagnosis, and an improved experience for cancer patients. RDC's will support the delivery of the NHS Long Term Plans ambition to diagnose 75% of cancer patients at an early stage and to ensure that, by 2028, 55,000 more people will survive cancer for at least five years. RDC's will also support the new 28 Day Faster Diagnosis Standard, which will be introduced from April 2020. RDCs will complement work to improve screening programmes, augment the potential of artificial intelligence (AI) and genomic testing and utilise Primary Care Networks to improve early diagnosis in their localities.

The intention of setting out the draft vision for RDCs is to enable Cancer Alliances and local providers to evolve the design and delivery of diagnostic services over five years, with the end goal in mind. In partnership with Cancer Alliances, NHSE will continue to refine the vision, as more is learnt about how best to implement RDCs.

NHSE's vision is to take a phased approach to the implementation of RDC's over a five year period. **NHSE advises that in 2019/20, all Cancer Alliances are expected to set up at least one RDC for patients with vague symptoms in line with section 5 of the specification. Some Cancer Alliances covering larger will also explore ways to expand the remit of RDCs, to improve cancer diagnostic provision for other patient cohorts.**

Some Cancer Alliances covering larger geographical areas and/ or those who have already piloted a proof of concept through piloting the MDC approach will be able to go further towards the vision and include additional patient cohorts in 2019/20.

2. Purpose of the report

The purpose of this report is to outline GM Cancer Alliances' plans for the initial implementation of RDC's in Greater Manchester during 2019/20, ensuring they are in line with NHSE and NHS Improvements Draft Rapid Diagnostic Centre: Vision and 2019/10 Implementation Specification (June 2019) described above. This report:

- Provides a short summary of the work to date in Greater Manchester which will assist with the implementation of RDC's in 2019/20
- Outlines a plan for the process which will need to be undertaken to develop RDC's in Greater Manchester throughout 2019/20.
- Proposes that as Greater Manchester has already piloted a Multidisciplinary Diagnostic approach for patients with vague symptoms on 2 sites that GM is in a position to develop phase 1 of RDC implementation on more than one site and extending the service to additional cohorts of cancer patients, wider than vague symptoms alone.

Details within this report have already been shared in a draft format with the Greater Manchester Cancer Alliance Senior Management Team.

3. Background to the development of RDC's in Greater Manchester

NHSE suggests that using an RDC service model to diagnose patients with vague symptoms builds on the evidence gathered during the piloting of Multidisciplinary Diagnostic Centres (MDC's). MDC's are similar service models to RDCs and were piloted over two years as part of the Accelerate-Coordinate-Evaluate (ACE) programme, a partnership between Cancer Research UK, Macmillan Cancer Support and NHS England.

Between April 2017 and April 2019 Greater Manchester Cancer Alliance was part of the ACE programme and operated at the Royal Oldham Hospital (Northern Care Alliance NHS Group) and Wythenshawe Hospital (Manchester University NHS Foundation Trust). The pilot project tested the concept of an MDC as a useful rapid diagnostic pathway for complex patients with 'vague' symptoms. Cancer was confirmed or excluded at the MDC; if cancer was either strongly suspected or confirmed after initial investigations, the patient was referred directly to a tumour specific Multidisciplinary Team, for a treatment plan to be determined.

In summary the GM MDC pilot project concluded that an MDC approach for this cohort of patients:

- Provides a clear, timely, accessible pathway for this group of patients.
- Demonstrates that over 90% of patients received a Yes/ No to cancer on the same day
- Produces a high rate of patient and staff satisfaction.
- Demonstrates that over 90% of patients found out whether or not they had cancer within 28 days.

The GM MDC pilot project (although based on a low volume of patients) provides Greater Manchester Cancer Alliance with a *proof of concept* in preparation for the implementation of RDC's in 2019/ 20 and mirrors the findings within the national draft document outlined on page 8; section 4.5.

4. Proposed next steps for the development of RDC's in Greater Manchester

In order to progress the development and implementation of RDC's in Greater Manchester Cancer during 2019/20, the Cancer Alliance propose to carry out the following:

July 2019

- During June and July 2019 - engagement with the 2 MDC sites (NCA and MFT) to gain an understanding of willingness to be part of Alliance RDC plans - ongoing
- Provide GM Cancer Alliance Senior Management team with an overview of the Draft national specification and proposed plans – 8/7/19
- Submit to NHSE Regional Cancer Leads the Alliances' draft outline plans for implementation of RDC's in line with national guidance – awaiting national template.

August 2019

- Sue Sykes (SS) and Sarah Taylor (ST) to gather and analyse data from across a number of suspected cancer referral pathways to establish how many patients would benefit from an RDC approach.
- ST to engage with GP's, emerging Primary Care Networks and GM Cancer Pathway Directors to discuss and agree potential triage options.
- SS to engage with relevant CCG's to ensure awareness of future proposed plans.
- Agree which sites during phase 1 will roll out an RDC approach for vague symptoms alone to a larger area and which site will add in additional symptom cohorts.
- Secure data analysis and People Affected by Cancer support.
- Receive feedback from NHSE on draft outline plans.

September 2019

- GM Cancer Alliance and proposed sites for phase 1 present at Greater Manchester Cancer Board (GMCB).
- GM Cancer Alliance submit detailed plans for RDC roll out over the next 4 years across GM to NHSE.
- Gain an understanding and scope any smaller scale projects that are being developed across GM.
- RDC development in collaboration with agreed sites post GMCB in September 2019.
- NHSE / Regional Leads provide feedback to GM Cancer Alliance on submitted plans.

Autumn 2019

- Development of job descriptions / roles for RDC Alliance and site teams.
- Agree governance arrangements.
- Work with Alliance and site financial teams to produce financial plan.
- Secure transformation funding.
- Recruit to GMCA RDC Project team.
- Recruit to RDC sites operational teams.
- Work with NHSE to confirm data requirements and health economist analytical support.
- Local operational agreements and governance are set up for RDC sites, to be in a position to receive referrals from January 2020.

By March 2020
Greater Manchester Cancer Alliance to have an understanding of:

- Which types of patients will be seen on which RDC site.
- How many patients can be seen on each site, by whom and for which cancer pathways.
- What diagnostic capacity is required.
- Cost and benefits analysis.
- What type of clinical team is required on each site.
- Significance of both primary and secondary care triage.

All the above will inform GGM Cancer Alliances' plans for the following 4 years, in order to be in a positon to develop an offer for the GM Cancer system.

5. Recommendations

The GM Cancer Board are asked to note the context, background and purpose of the paper and approve the proposed next steps for implementation of phase 1 of RDC's across Greater Manchester.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number 8

Greater Manchester Cancer

Greater Manchester Cancer

Cancer Board – Highlight Report
July 2019

This report covers high level achievements from across Greater Manchester Cancer pathways and programmes from May, June and July.

1. CURE

6 month pilot data for the CURE programme is now available. Headline data includes:

- Quit rate at 4 weeks =42%
- At 12 week follow up (first 3 months of CURE), 332 patients have stopped smoking since hospital admission

The programme was also featured in external press communications from GMHSCP, following the publication of new smoking figures demonstrated a drop faster than the national average in Greater Manchester.
CURE also presented to Northern Ireland Smoking Cessation Nurses resulting in a follow-up request to present to their Chief Executives and Department for Health about the CURE model; they have expressed desire to apply for transformation funding in order to implement the model in their area.

2. Prehab4Cancer

In the first 8 weeks since its launch in April, the Prehab programme had 170 referrals with a 92% uptake rate.
The team was also asked to present at the World Prehab Conference on 2 and 3 July, with John opening the second day's plenary session. National prehab guidance was launched at the event, developed in collaboration with a number of stakeholders including the Prehab4Cancer team.

3. Launch of Oral Health Resource

The GM oral health resource, developed by the Head and Neck pathway, has launched this month and was demonstrated to healthcare professionals at an event on 10 July.
The guide is designed to support healthcare professional to detect early signs of cancers and also support them to offer good dental care during cancer treatment. Presentations at the event included those from the Chair of the Local Dental Network, Oral Surgeons, Cancer Research UK and patient representatives.

4. First GM Transperineal Prostate Biopsies

The first transperineal prostate biopsies have been performed at Salford and The Christie, in an outpatient clinical procedures room rather than under general anaesthetic in theatre. This was supported by the cost of the 1 day training from the prostate best time pathway budget. This means the patient can move more swiftly to biopsy (reducing wait times associated with theatre admission) and reduces the risk of infection. Patients have well tolerated the procedure. Two further Consultant Urological Surgeons from Greater Manchester are arranging to train on this procedure shortly, in order to introduce this practice into their GM Sector Urology hub site.

5. **LWBC**

During a Health and Wellbeing event at HiM in May, the idea for a 'Gateway-P' patient supporting resource was created: a digital offer to patients including links to trusted information sources, an event's directory and general support for those self-managing or have been discharged. This idea is now being pursued via bids to both digital and T2 funding.

6. **Transforming Aftercare**

The Transforming Aftercare project is progressing well. Workshops continue with individual breast teams, the outcomes of which are action plans to get the stratified follow-up pathway in place. Tameside will be the first Trust to start on the new pathway on 1st September 2019. Work has also begun to put a supported self-management pathway in place for colorectal at Stockport. Work to identify the best IT system to track patients on a supported self-management pathway has gained agreement on one GM-wide solution (Info-Flex).

7. **Award Nominations for Specialist Palliative Care Teams**

Specialist Palliative Care Teams across SRFT and the community have been shortlisted for the Nursing Times Workforce Team of the Year.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Paper number 9

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	22 July 2019	
Title of presentation:	NHS Transformation Unit Programme Update – Single Service Model for Specialist Gynae Cancer Surgery	
Purpose of the presentation:	To update the GM Cancer Board on the progress of the GM Gynae Cancer Surgery Specification approvals through the GM governance arrangements.	
Reason for Presentation: *Please tick appropriate box*	☐	***Decision***
	☐	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes **Improved patient experience** **Reducing inequality** **Minimising variation**	The aim of the single service arrangements overall is to deliver high quality holistic care for patients to improve survival and quality of life. This will be done by bringing specialist surgical expertise together through new operational and governance arrangements for gynae cancer surgery. Patient choice will improve, and variation will be reduced through more effective joint working across the specialist teams and the local diagnostic units; this will be facilitated by new working arrangements e.g. MDT arrangements.	
Operational / financial efficiency	Bringing expertise together and addressing variation and will support the delivery of the financial and operational efficiencies described in the GM Cancer Plan.	
Author of presentation and contact details	**Name:** Sarah Maynard-Walker **Title:** Managing Consultant, NHS Transformation Unit **Email:** sarah.maynardwalker@nhs.net	

Introduction

2.1 The GM Gynae Cancer Surgery Specification sets out an ambitious plan for specialist gynae cancer surgery services, aimed at improving patient experience, choice and outcomes through delivery of high quality, holistic care and reduced variation. The new specification sets out how this will be achieved, by bringing the 2 gynae surgical teams together from St Mary's Hospital (part of Manchester NHS Foundation Trust) and The Christie NHS Foundation Trust, to work as one team and collaboratively with the local cancer diagnostic units, through a number of new and reviewed operational processes and standards.

The vision for this service is:

"The service will deliver improved outcomes and leadership, both locally and nationally in Gynaecology cancer services, through the continual involvement of patients, increased access to research trials, constant innovation including implementation of latest technologies, and transparent dissemination of high-quality data."

2.2 Upon implementation of the specification, women requiring surgical treatment of gynae cancer surgery will receive this from a single highly skilled specialist team of gynae oncology surgeons and clinical nurse specialists, with wraparound support from other sub-specialties to ensure the best possible holistic care and wellbeing of patients, their carers and families from diagnosis to treatment and beyond. The service will be underpinned by an enhanced focus on research and clinical trials, capitalising on and expanding the existing academic prowess of the NHS and universities in Greater Manchester to pioneer more effective and personalised treatment for gynae cancers.

2.3 The specification and its supporting documents outline the model of care, requirements for its implementation, how it will operationally function and how performance and outcomes will be measured. The model of care is structured around the P4 Medicine principles: prediction, prevention, personalisation and participation.

2.4 To ensure effective joint working as a single surgical service, new operational arrangements and principles have been set out within the specification; these include:

All referrals from the local cancer diagnostic units into the GM Gynae Cancer Surgery Service will be routed through and managed by a 'central hub'. At present, patients are referred on a geographical basis into either The Christie or St Mary's Hospital.

A single specialist multidisciplinary team model will be in place at the Lead Provider site to facilitate joint treatment decisions;

- The place of surgery will be defined by patient's clinical need. Patients will be triaged to the most appropriate clinician, in the shortest timeframe, based on their specific needs, which should account for geographical location, informed by patient choice.

A single clinical lead will be in place as part of the single service governance arrangements.

There will be greater participation of patients and service users in:

- The formal governance of the service, becoming integral to the quality assurance of the service as it develops.
- Research and clinical trials, with an ambition for the GM Gynae Cancer Surgery Service to be recognised nationally and internationally as a leader in clinical research. There is a requirement for the service to actively increase the number of participants in research from BME groups, who are currently less well represented in research trials.

A single data collection process will be in place to ensure single audit and reporting of outcomes for all cases.

Outcomes data will be published to inform future service design requirements and personalised treatment.

A single rota with 24/7 on call covering both the Lead and Key Provider sites.

2.5 It expected that the service will operate within current funding arrangements, with opportunities for efficiencies being identified through the new service governance structure.

2.6 The specialist and local structures will be complementary and streamlined to ensure that they are effective and efficient, whilst avoiding duplication, reduce handovers, and minimise the timelines from diagnostics to treatment.

2.7 The service is expected to work collaboratively across the wider GM Gynae Cancer Service, including the local diagnostic units; the specification sets out requirements for this working relationship and recommends a review of diagnostic units is undertaken within 12 months of the specification approval to:

- Ensure enhanced provision (e.g. 'one stop clinics') are in place and coterminous with children and maternity services across the established conurbation;
- Support delivery of national standards and targets;
- Identify where new models of care should be developed aimed at improving:
  - patient flow through the pathway
  - the health and wellbeing of cancer patients to deliver personalised models of care for patients and support for patients in the community
  - stratification of patients on the basis of Health Needs Assessment and risk of recurrence, to facilitate a shift towards supported self-management where appropriate.

2.7.1 As the CCGs commission the local diagnostic units, Directors of Commissioning have been engaged and they are supportive of both the specification and the proposed review.

The final version of the specification can be shared with GM Cancer Board members, should they wish to review it in more detail.

RECOMMENDATIONS:

For the GM Cancer Board to note that:

- The specification has been approved by the Responsible Commissioner, Jon Rouse, on the recommendation of the GM Specialised Commissioning Oversight Group and Directors of Commissioning.

- The Greater Manchester Joint Commissioning Board has endorsed the new single service for Gynaecological Cancer and support a review to be undertaken of the gynae cancer local diagnostic units within the next 12 months.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Paper number 10

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	22 July 2019	
Title of presentation:	**North West Radiotherapy Network Update**	
Purpose of the presentation:	To update the GM Cancer Board on developments of the North West Radiotherapy Network and governance arrangements.	
Reason for Presentation: *Please tick appropriate box*	☐	***Decision***
	☐	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes **Improved patient experience** **Reducing inequality** **Minimising variation**	The new national radiotherapy specification published last year: https://www.engage.england.nhs.uk/consultation/radiotherapy-service-specification-consultation/ defined network approach between radiotherapy centres in the North West, designed to improve outcomes, reduce variation in quality and enable access to the appropriate team of experts able to deliver the full range of cancer specific clinical care, clinical trials and advanced radiotherapy technologies**.** It will be done by bringing together specialist radiotherapy centres and expertise, through a new operational structure and governance arrangements, through the ODN. Patient choice will improve, and variation will be reduced through more effective joint working across the specialist teams and the local radiotherapy units.	
Operational / financial efficiency	Bringing expertise together and addressing variation and will support the delivery of the financial and operational efficiencies described in the GM Cancer Plan.	
Author of presentation and contact details	**Name:** Thomas Thornber **Title:** Director of Strategy, Christie Hospital **Email:** **Thomas.Thornber@christie.nhs.uk**	

North West Radiotherapy Network Update

1. Introduction

The publication of the nation radiotherapy specification and accompanying Operational Delivery Networks (ODN) specification initiated a defined network approach between radiotherapy centres. The North West Network includes the below radiotherapy providers.

a) Lancashire Teaching Hospitals NHS Foundation Trust

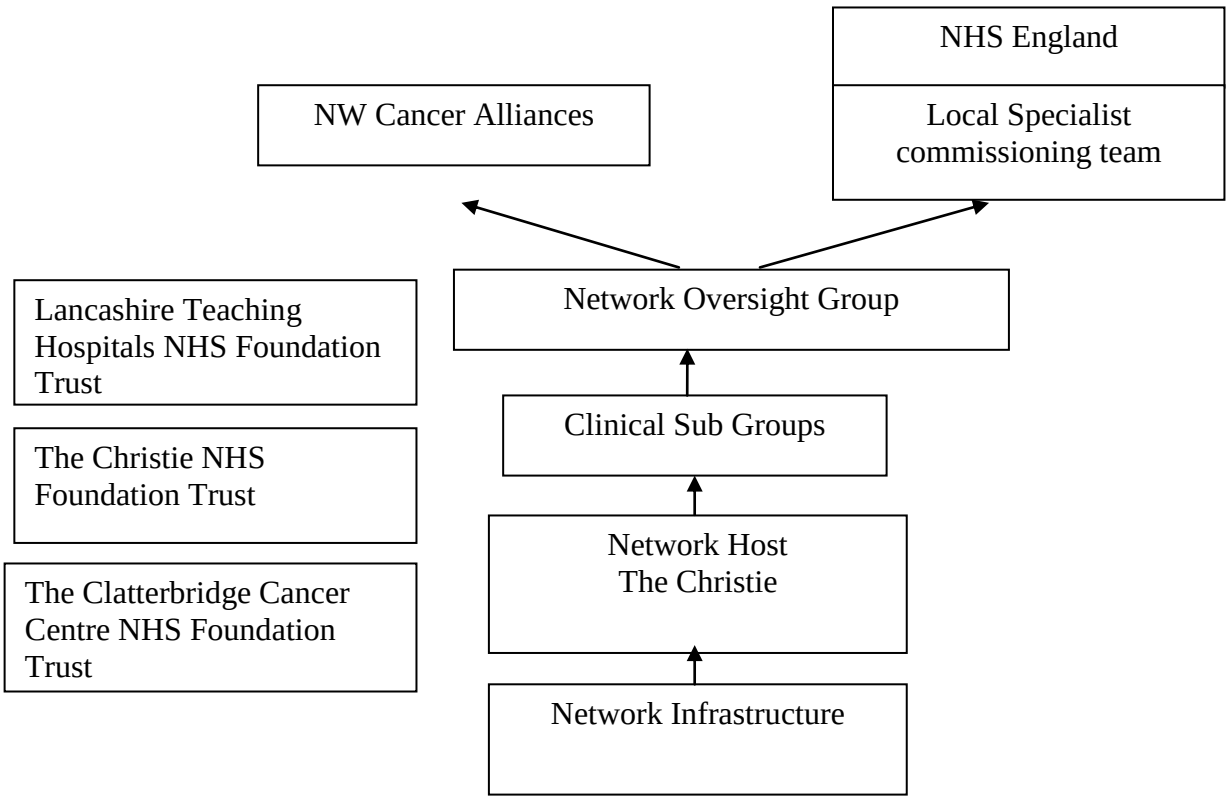
b) The Christie NHS Foundation Trust

c) The Clatterbridge Cancer Centre NHS Foundation Trust

2. Key Principles

The Specification is designed to improve outcomes, reduce variation in quality and enable access to the appropriate team of experts able to deliver the full range of cancer specific clinical care, clinical trials and advanced radiotherapy technologies

3. Network structure



4. Accountabilities

- The Network is accountable to NHS England through the Network Host and via the local specialist commissioning team. North West commissioning representation to be included on the network oversight group.
- The Network Oversight Group has operational responsibility to the participant Cancer Alliances. Named lead officers from each Alliance will provide formal links into the Cancer Alliances
    - Greater Manchester Cancer – David Shackley
    - Cheshire and Merseyside – Liz Bishop
    - Lancashire and South Cumbria – Gerry Skaile's

5. Scope

Annual Programme of work: To be agreed and signed off between Network Oversight group and Cancer Alliances. Prioritisation in line with the key principles described above.

Scope of activity to include:

- Standardise Clinical pathways and practice
- Demand and Capacity planning
- Workforce development
- Research Access & New Technology adoption

6. **Service alterations**:

Changes may have an impact on overall Network activity flows, and, potentially, cross network flows, service sustainability and workforce. Therefore any proposals to alter access must be approved by individual providers, the Cancer Alliance(s) and Specialised Commissioners and may be subject to public involvement duties.

7. Next Steps

- Confirm MOU and Terms of reference
- Confirm infrastructure funding and appoint.
- North West Radiotherapy service review
- Prioritisation of programme Annual Plan Approval December 2019

8. Recommendations

The GM Cancer Board is asked to note the context, background and purpose of the paper and approve the proposed next steps for implementation of the NW Radiotherapy ODN plan.