GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Agenda

Meeting time and date: 8.00–9.30am, 20th January 2017

Venue: Mayo Building, Salford Royal

Chair: Richard Preece

#	Item	Type	To	Lead	Time
1	Welcome and apologies	Verbal	-	Richard Preece	5′
2	Minutes of the last meeting	Paper 1	Approve	Richard Preece	5′
3	Action log and matters arising	Paper 2	Note	Richard Preece	5′
4	The Greater Manchester cancer plan				
	▪ Covering paper	Paper 3	Note	Dave Shackley	15′
	▪ *Achieving world-class cancer outcomes: taking charge in Greater Manchester*	Paper 4	Approve	Dave Shackley	
	▪ Next steps for the cancer plan	Presentation	Discuss	Dave Shackley	
5	The Greater Manchester User Involvement Steering Group	Paper 5		David Makin, Nabila Farooq	10′
6	Greater Manchester Cancer: Vanguard Innovation update	Paper 6		Jenny Scott	10′
7	Transformation of surgical services	Presentation	Discuss	Leila Williams	15′
8	Cancer and the 100,000 Genome Project	Presentation	Discuss	John Radford	15′
9	Future meeting dates	Verbal	Discuss	Tom Pharaoh	5′
10	Any other business	Verbal	-	All	5′
11	Papers for information				
	▪ Board response to modernising radiotherapy consultation	Paper 7			

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NHS in Greater Manchester

Greater Manchester Cancer

Paper number 1

Greater Manchester Cancer Board

Minutes of the meeting held on

Friday 16th December 2016 at Salford Royal

In attendance

Voting members				
GM Health & Social Care Partnership team		Richard Preece	RPre	Executive Lead for Quality, GMHSC Partnership (Chair)
Chair of the AGG of CCGs		Caroline Kurzeja (for Kiran Patel)	CK	Chief Officer, NHS South Manchester CCG
Provider trusts	Central Manchester	Darren Banks (for Mike Deegan)	DB	Director of Strategy
	Salford	Jack Sharp (for David Dalton)	JSh	Director of Strategy
	Stockport	Ann Barnes	ABa	Chief Executive
	The Christie	Roger Spencer	RS	Chief Executive
	Pennine Acute	Roger Prudham (for David Dalton)	RPru	Deputy Medical Director
Stakeholders				
People affected by cancer		Nabila Farooq	NF	
		David Makin	DMa	
Third sector advisory group representative		Donna Miller	DMi	Associate Director of Policy & Development, Black Health Authority
Delivery				
Medical Director		David Shackley	DS	Medical Director, Greater Manchester Cancer
Director of Commissioning – GM Cancer Services		Adrian Hackney	AH	Director of Commissioning – GM Cancer Services, NHS Trafford CCG
Vanguard Innovation Programme Director		Jenny Scott	JSc	Programme Director, Greater Manchester Cancer Vanguard Innovation
Chair of Trust Directors of Operations Group		Fiona Noden	FN	Chief Operating Officer, The Christie NHS FT
Nursing Lead		Cheryl Lenney	CL	Chief Nurse, Central Manchester University Hospitals
Chair of Cancer Education Manchester		Cathy Heaven (for Richard Cowan)	RC	Vice-Chair, Cancer Education Manchester; Associate Director, Christie School of Oncology
AHSN representative		Peter Elton (for Mike Burrows)	PE	Clinical Director, GM&EC Strategic Clinical Network
Programme Director (interim)		Thomas Pharaoh	TP	Associate Director, Greater Manchester Cancer
Other members of cancer support team				
Macmillan User Involvement Team		Lucie Francis	LF	Macmillan User Involvement Team Leader
Visitors and observers				
Gareth Evans, Consultant in Medical Genetics and Cancer Epidemiology			Andrew Wardley, Consultant Medical Oncologist, Systemic Anti-Cancer Therapies Director – Greater Manchester Cancer	

Members sending apologies and no deputy

Lead CCG	Nigel Guest	NG	Chief Clinical Officer, NHS Trafford CCG
Primary care providers	Tracey Vell	TV	GP, Chief Executive of Manchester LMC
Local authorities	Steven Pleasant	SP	Chief Executive, Tameside Metropolitan Borough; Interim Accountable Officer, NHS Tameside and Glossop CCG
NHS England specialised commissioning	Andrew Bibby	ABi	Assistant Regional Director of Specialised Commissioning (North), NHS England
MAHSC Cancer Domain Academic Lead	Salvador Moncada	SM	MAHSC Cancer Domain Academic Lead
GM Director of Population Health Transformation	Jane Pilkington (for Wendy Meredith)	JP	Head of Public Health Commissioning
Transformation Unit representative	Leila Williams	LW	Chief Executive, NHS Transformation Unit

1. Welcome and apologies

RPre welcomed members and apologies were noted.

2. Minutes of the last meeting

The board approved the minutes of the meeting on 18th November.

3. Action log and matters arising

The board noted the action log. It noted that all actions were complete or on the agenda except for the action to collate a Greater Manchester response to the consultation on *Modernising Radiotherapy Services in England*.

DB informed the board that he had drafted some feedback and that this had been shared with key board members. He noted that while there was much in the consultation document that Greater Manchester would want to support there was a recommendation about the hosting of specialist MDTs that could be disputed. It was noted that the consultation was likely to be trying to tackle issues elsewhere in the country that had already been resolved in Greater Manchester. RS stated that MDT arrangements in Greater Manchester were significantly advanced and that there was no suggestion that these should change.

Action: TP to collate feedback and submit a Greater Manchester Cancer Board response to the radiotherapy consultation before 23/12

4. Voluntary sector advisory group workshop update

Donna Miller from the Black Health Association attended the meeting to provide an update on the workshop of 13th December. The board heard that the SCN team had facilitated a discussion around the formation of the board's Voluntary, Community and Social Enterprise Advisory Group.

She informed the board that the workshop was well attended and that delegates from the third sector welcomed the opportunity to be involved with the work of the Greater Manchester Cancer. DMi outlined what the group thought it could offer the board, including:

- Early mapping of the region's assets
- A link to difficult to reach communities
- Support for an equality impact assessment of the cancer plan
- A role in co-producing future policy.

DMi noted that the group had been asked to identify one representative to sit on the board. The board heard that having discussed this subject the group concluded that this would not give its members sufficient involvement and had arrived at two different options to present back to the board:

1. One permanent member to be joined by an additional member of the group at each meeting dependent on topics to be discussed
2. Multiple (e.g. four) representatives rotating through a single seat on the board at each meeting.

DMi informed the board that the group had made a number of requests, including:

- Access to the terms of reference of the Greater Manchester Cancer Board
- Support with room booking and administration
- The opportunity to add items to the board's agenda
- Voting member status for its representative(s)
- Papers in a timely manner
- The consideration of expenses.

RPre expressed a preference for continuity and therefore the first membership option presented. RS informed the board that he had attended the workshop on its behalf and welcomed the level of engagement from the third sector and the speed with which the group had formed. He shared the preference of the first membership option and this was agreed by the board under most circumstances.

RPre stated that all members of the board were equals regardless of the voting arrangements set out in the terms of reference and that voting was a mechanism unlikely to be used by the board. In addition he stated that the Greater Manchester Health and Social Care Partnership was undertaking a broader piece of work on support and expenses for third sector involvement. The board heard that the Voluntary, Community and Social Enterprise Group would meet again in January.

Action: JH to provide third sector group with all information requested

5. Vanguard Innovation programme

JSc presented a paper providing an update on the Vanguard Innovation programme. She informed the board that the programme had received all of the transformation funding for year two that it had asked for from NHS England. The board noted the map of Vanguard Innovation activity that had been requested at the last meeting. ABa noted the absence of activity in the south east of the region and reiterated the need for system as a whole to feel ownership of the Vanguard Innovation programme. RPre asked that Eastern Cheshire be added to the map.

DB thanked JSc for the helpful update paper but noted that such papers did not allow the board to hold the Vanguard Innovation programme to account. He suggested that the board should see a map of information that it should expect to see, and the decisions it would be asked to take, over the course of the programme. JSh noted that it had felt recently like there was more visibility and shared ownership of the Vanguard Innovation programme. RPre asked that a specific action be added to the agenda of the Vanguard Innovation Oversight Group regarding increasing the engagement of the cancer system and its ability to contribute to the programme.

Action: JSc to schedule Vanguard Innovation Oversight Group discussion of increasing system engagement and ownership

The board congratulated the Vanguard Innovation programme on securing the full funding from the NHS England New Care Models Team. DMi suggested that the programme office form links with the new third sector group to help with community engagement.

6. Developments in breast cancer:

DS introduced the topic. He noted that developments in breast cancer were a good example of how the introduction of evidence-based interventions could be delayed by national evaluation processes. He posed the question of whether there was a way that Greater Manchester could adopt such initiatives earlier.

Commissioning adjuvant bisphosphonates across Greater Manchester

Andrew Wardley attended the meeting to outline the case for use of adjuvant bisphosphonates to prevent the recurrence of breast cancer in postmenopausal women. The board heard that there was evidence of an 18% improvement in survival associated with this treatment and that there were associated benefits for bone health.

The board heard that the treatment was being offered in other parts of the country and that breast cancer clinicians locally had been trying to raise its profile. AW outlined a recent survey of breast oncologists nationally, which revealed that almost half were using adjuvant bisphosphonates in this cohort of patients.

DS noted that the charity Breast Cancer Now estimated that 1,000 lives could be saved through this treatment every year, which would equate to 20 women in Greater Manchester. RS noted that this topic was the subject of a recommendation in the national cancer strategy and that the role of the board should be to consider its early adoption while national guidance was awaited.

The board felt that there seemed to be a strong clinical case for the use of adjuvant bisphosphonates to prevent breast cancer recurrence in postmenopausal women. DMa reported that there was considerable patient impatience on this subject. The board agreed that Greater Manchester should not wait for national guidance but should explore the case further. RPre suggested that a business case should be drawn up and asked AH to lead on this. DB noted that this work should be linked to other breast cancer work as part of theme 3 of the GMHSC Partnership's work.

> **Action: AH to lead the development of a business case for the use of adjuvant bisphosphonates to prevent recurrence of breast cancer in postmenopausal women**

Targeted breast cancer prevention in Greater Manchester

Gareth Evans attended the meeting to outline the case for the use of anastrozole, an aromatase inhibitor, to prevent breast cancer in postmenopausal women with increased risk of the disease. He presented the results of a study which showed that after a median follow up of 7 years there were 53% fewer breast cancers in women treated with anastrozole.

The board heard that draft NICE guidance was being consulted on which was likely to recommend the consideration of anastrozole in women with moderate or high risk of breast cancer and that Greater Manchester had the opportunity to lead the way in this area. The board heard estimates that there are 56,000 women at moderate risk of breast cancer in Greater Manchester and 28,000 at high risk. It heard that up to 200 breast cancer cases could be prevented each year through this intervention.

GE noted that the present route to risk assessment of breast cancer was through family history clinics and that implementation of this treatment would need proactive risk stratification rather than a reliance on women coming forward to family history services. RPru noted the need to ensure that, if adopted, this treatment is available to all women rather than those who already engage with health services and screening programmes.

RS noted that again that this topic was the subject of a recommendation in the national cancer strategy and was being discussed today in the hope that it can be included in the Greater Manchester cancer plan. The board asked AH to lead the development of a business case. CK offered to support AH in this and the bisphosphonates business case.

Action: AH to lead the development of a business case for the use of anastrozole to prevent breast cancer in postmenopausal women at high and moderate risk

7. Transformation of surgical services

RPre noted that this item was deferred to a future meeting.

8. Any other business

DMa stated that the board should seek more publicity for the work that it is doing. RPre noted that there was likely to be an opportunity to do so around the publication of the cancer plan. TP informed the board that he had made links with the communications team of the Greater Manchester Health and Social Care Partnership and that a proposal would be prevented to a future meeting.

CK informed the board that Macmillan Cancer Improvement Partnership was holding a showcase event in January to be attended by Macmillan's Chief Executive. She noted that the a similar update could be presented to the board.

RS noted the announcement that the Manchester Cancer Research Centre had renewed its CRUK major centre status with accompanying investment of £42m over five years, including the Experimental Cancer Medicine Centre award and complementary to the Biomedical Research Centre award. The board heard that the MCRC was now one of only two CRUK major centres nationally.

AH gave an update on the board's infrastructure. The board heard that a paper would be going to CCG and provider Directors of Finance in January. He thanked The Christie and Macmillan Cancer Support for their roles in underwriting the costs of some of the existing team to provide reassurance while this process continues.

ABa noted that a multi-organisational team was coming together to arrange a system-wide workshop in February to develop proposals for developing radiology services in Greater Manchester.

RPre reflected that this was the fourth meeting of the board. He noted that its membership had been augmented and that it should be happy with the progress that it was beginning to make.

9. Papers for information

The papers provided for information were noted.

Paper number 2

Greater Manchester Cancer Board

Action log

Prepared for the 20th January 2017 meeting of the board

	ACTION	AGREED ON	STATUS
1	TP to collate feedback and submit a Greater Manchester Cancer Board response to the radiotherapy consultation before 23/12	16th December 2016	Completed – response circulated in papers for information
2	JH to provide third sector group with all information requested	16th December 2016	Completed
3	JSc to schedule Vanguard Innovation Oversight Group discussion of increasing system engagement and ownership	16th December 2016	Completed – standing agenda item on oversight group agenda – Programme Director update on agenda
4	AH to lead the development of a business case for the use of adjuvant bisphosphonates to prevent recurrence of breast cancer in postmenopausal women	16th December 2016	Incorporated into cancer plan for delivery by May 2017 - to be removed from log and incorporated into implementation plan
5	AH to lead the development of a business case for the use of anastrozole to prevent breast cancer in postmenopausal women at high and moderate risk	16th December 2016	Incorporated into cancer plan for delivery by May 2017 - to be removed from log and incorporated into implementation plan

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NHS in Greater Manchester

Paper number 3

Greater Manchester Cancer

Achieving world-class cancer outcomes: Taking charge in Greater Manchester 2017-21

Covering note

1. Introduction

The purpose of this paper is to provide a covering note to the Greater Manchester Cancer Board to introduce the final draft of the proposed Greater Manchester cancer plan. The plan has been developed by the whole cancer system and is presented to the 20th January 2017 meeting of the cancer board for its approval.

2. Development of the plan

The plan has been subject to a period of broad engagement and formal consultation running from late September to early January. The following groups and bodies have been involved in its development (where this was at a specific meeting the date is given).

Greater Manchester Health and Social Care Partnership

- Joint Commissioning Board Executive (23/11/16)
- Joint Commissioning Board (13/12/16)
- Provider Federation Board (18/11/16)
- Primary Care Advisory Group (23/11/16)
- Transformation Portfolio Group (15/12/16)
- Association Governing Group of CCGs (03/01/17)
- Directors of Public Health Group (06/01/17)

Greater Manchester Cancer

- User Involvement Steering Group
- Pathway Clinical Directors and Clinical Pathway Boards
- Cancer Education Manchester
- Vanguard Innovation Clinical Leads and programme office
- Voluntary Community and Social Enterprise Advisory Group (13/12/16)

Commissioners

- CCG Directors of Commissioning
- CCG Cancer Commissioning Managers
- NHS England

Hospital providers

- Directors of Operations Group
- Directors of Finance Group

- Directors of Nursing Group (18/11/16)
- Directors of Strategy Group
- Trust Cancer Leads (17/10/16)

Partners

- Greater Manchester and East Cheshire Strategic Clinical Network
- Healthier Futures
- Macmillan Cancer Support regional team
- Cancer Research UK regional team
- Macmillan Cancer Improvement Partnership
- Macmillan GPs Group
- Black, Asian and Minority Ethnic Cancer Network (01/12/16)

A wide range of feedback has been received during this engagement period. Responses have ranged from comments from individual practitioners to organisational responses from CCGs, provider trusts and third sector partners. The plan has been developed substantially in response to this feedback.

3. Summary of the plan

The plan sets out the ambitions for Greater Manchester Cancer, the cancer programme of the GMHSC Partnership. It is set out in **eight domains** reflecting a combination of the five key areas for change set out in Taking Charge and the six key workstreams of the national cancer strategy.

The plan sets out a summary of the work that is already happening in each domain. It then sets specific and measurable objectives for each domain and our current performance against them.

While all are important, six of them have been picked out as **key objectives**. This will allow an at-a-glance assessment of our performance across the cancer system and across the pathway.

1.	**We will reduce adult smoking rates to 13% by 2020** One in five adults in Greater Manchester still smoke nearly a decade after smoking was banned in enclosed public places in England.
2.	**We will increase one-year survival to more than 75% by 2020** Our rate of survival one year after cancer diagnosis is rising but further substantial improvement will need additional focus on detecting cancers at an earlier stage.
3.	**We will prevent 1,300 avoidable cancer deaths before 2021** We have some of the highest rates of avoidable cancer deaths in the country – matching the national average will save hundreds of lives.
4.	**We will offer class-leading patient experience, consistently achieving an average overall rating of 9/10 in the national survey from 2018** Our patients report good experience compared to other conurbations with an average overall rating of 8.76 in 2015, but there remains room for improvement.
5.	**We will consistently exceed the national standard for starting treatment within 62 days of urgent cancer referral** Working as a system we have met the 62-day standard for a number of years, but we want to keep reducing the amount of time people wait to start their treatment.
6.	**We will ensure that the Recovery Package is available to all patients reaching completion of treatment by 2019** The Recovery Package is a combination of important interventions that, when delivered together, can greatly improve the outcomes and coordination of care.

The plan then sets out what we propose to do to meet our objectives. Each domain has numerous proposed interventions/pilots/projects but there are a number of **key projects** with the aims of preventing avoidable deaths, reducing variation and improving experience.

Preventing Avoidable Deaths

1. Prevention – particularly **smoking**
2. Public awareness – 20,000 cancer champions
3. Screening – improved uptake
4. **Risk-based targeting** – e.g. lung health check
5. New/ streamlined diagnostics – e.g. MDCs

Reducing Variation

1. Primary care education
2. Refresh co-produced clinically-led specificatns
3. Radiology/ pathology digital virtual networks

Improved experience

1. Recovery package
2. Real-time user feedback
3. Better information/ tools
4. Personalised after-care

Much of the work set out in the plan will be delivered by the current and proposed Greater Manchester Cancer infrastructure. A paper is being presented to providers and CCGs in January to seek to secure ongoing funding of this.

A substantial part of the plan in 2016/17 and 2017/18 is part of the vanguard innovation programme and funded by NHS England's New Care Models Team.

Transformation funding will be sought to deliver other key parts of the programme and, if appropriate, to roll out successful pilots from the vanguard innovation programme beyond 2017/18.

4. Key interfaces with broader GMHSC Partnership programme

- Many of the measures necessary to prevent incidence of cancer (smoking reduction, lifestyle and activity) are part of broader efforts to improve population health
- Through implementing elements of the plan we are likely to increase demand for already stretched diagnostic capacity
- The current and future programmes for transformation of specialist services involve significant changes to cancer surgery services

5. Risks and support required

- The plan contains a substantial amount of work, much of which contributions from all parts of the cancer system. Support will be required to encourage this.
- Support required for the agreement of contributions from the system towards the baseline costs of the infrastructure of the Greater Manchester Cancer Board.
- The proposed accountable cancer network model as part of cancer vanguard programme requires further substantial GM system debate and engagement.
- Transformation funding will be sought to deliver some of the signature proposals in the plan, including lung health check (if pilot successful) and delivery of the recovery package.

6. Proposed next steps

Subject to approval by the Strategic Partnership Board the plan will be published in March 2017. It will be published alongside a shorter more accessible version.

The plan will be accompanied by a number of annexes setting out the contributions required from each part of the cancer system to deliver it:

- Greater Manchester Health and Social Care Partnership
- Commissioners
- Hospital providers
- Primary, community and social care providers
- Clinical Pathway Boards

An equalities impact assessment will be carried out by March. A full implementation plan will then be developed by June 2017.

7. Recommendation

The Greater Manchester Cancer Board is asked to approve the final draft of *Achieving world-class cancer outcomes: Taking charge in Greater Manchester* for presentation to the Strategic Partnership Board in February.

Paper number **4**

Achieving world-class cancer outcomes: Taking charge in Greater Manchester

Version 0.7

For approval

See separate PDF

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

WE ARE MACMILLAN. CANCER SUPPORT

Greater Manchester Cancer

Macmillan User Involvement Programme

Paper number 5

The Greater Manchester Cancer User Involvement Steering Group

Update

January 2017

- The Greater Manchester Cancer Steering Group was **established 18 months ago** as part of the (then) Manchester Cancer Macmillan User Involvement Programme.
- It is a **representative group** of people affected by cancer, with multiple links cancer patient and carer group across the region.
- It is responsible for **monitoring, evaluating and guiding** the Macmillan User Involvement Programme within Greater Manchester Cancer, with the support of the Macmillan User Involvement Team.
- The current membership of the group stands at **18 people affected by cancer** living in Greater Manchester and East Cheshire. Those that cannot attend regular meetings have the opportunity to feed into meetings remotely.
- The steering group is represented at the **Greater Manchester Cancer Board** by its two service user representatives: David Makin and Nabila Farooq.
- Service user representatives on all clinical pathway, vanguard innovation and other groups **regularly report and update** steering group members on developments, progress and outcomes of work.
- The steering group may then **make recommendations** on actions that need to be taken or points that need to be raised through the wider network of service user representatives on behalf of people affected by cancer.
- The steering group meets **monthly** at locations across Greater Manchester and East Cheshire.
- From January 2017 the steering group's meetings have been moved **in line with the Greater Manchester Cancer Board**.
- This will allow board papers to be distributed to steering group members so they can be considered, discussed and comments can be **fed to the board** through its service user representatives.
- This revised set up will also allow the steering group representatives to attend the board knowing they are consistently **representing the wider views** of people affected by cancer, as their role requires.
- As such, the Greater Manchester Cancer Board will have from February a **standing agenda item** for updates and feedback from the steering group.

Paper number 6

GREATER MANCHESTER CANCER VANGUARD INNOVATION

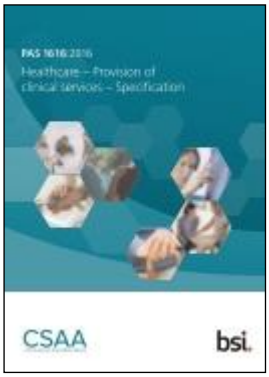
PROGRESS UPDATE (JANUARY 2017)

1.0 UPDATE ON INNOVATION PROJECTS

Good progress continues to be made with Vanguard Innovation with some specific examples being detailed below. A revised map of the locations for the full range of clinical projects within Vanguard Innovation will be presented in the February 2017 update report.

Work stream	Summary Progress
Involvement of People Affected by Cancer (PAbC)	An overarching principle of Vanguard Innovation is that PAbC are involved in every group set up and meeting held. We have worked closely with the Macmillan user involvement team in the former Manchester Cancer to seek nominations. This has now been achieved and is already bringing significant benefits to our work. A meeting was recently held with key members of the Black Health Agency (BHA) which has provided invaluable insights into how the Vanguard can engage more effectively with a range of communities and populations.
Prevention	There are 4 projects within our prevention work stream and these are aligned with broader work in GM H&SC Partnership. This work stream is progressing a number of innovations in cancer prevention which are described in the attached slides (see Appendix 1). NHSE is particularly interested in this aspect of our work due to the potential for large scale, replicable change.
Early diagnostics	**'Query Cancer'** – operational plans are being established to pilot the 2 one-stop clinics at PAHT and USHM. GPs in these catchment areas will refer patients initially with non specific but concerning ('vague') cancer symptoms to these clinics and patients will receive a definitive 'Yes / No' diagnosis within 7 days of receipt of referral. The majority of patients will not have cancer and will be referred back to their GP with a recommended management plan. Patients with cancer will be fast-tracked onto an appropriate pathway. This work is aligned with the ACE2 project in these areas so they complement and augment each other. The metrics to measure the impact of these pilots have now been agreed and patients are being virtually triaged for baseline data comparisons. The UHSM pilot of vague symptoms (ACE2) will commence in February 2017 and Oldham in March 2017. Other specific cancer pathways will be piloted during 2017/18. A meeting of clinical leads at UHSM is planned for 13th Jan 17 to confirm the local pathway to be in place for the multidisciplinary centre (MDC) model. **'Faster Diagnosis'** – this one-year project in Bolton to test out how to fast-track all cancer diagnosis, including staging, within national targets has now commenced. Progress to date is as follows: • KPIs in development, aligning with existing 2016/17 CQUINs which already have a strong emphasis on faster diagnosis • Clinical Steering Group established • Lung Operational Group established and processes being developed to

	introduce straight to CT from abnormal chest x-ray • Multi-disciplinary lower GI direct to test project group established and meeting weekly – membership includes operational managers, commissioners, clinical staff and referral and booking team • Upper GI Pathway Group in process of being established with some commonality in membership with lower GI to ensure alignment • Direct to test patient and GP information packs drafted for colonoscopy and currently under review by the CCG for further primary care engagement in early 2017 • Recruitment underway for posts to support the pilot • Plans for user involvement and patient engagement underway with support from GM Vanguard • Team members from Projects 6 and 7 communicate on a regular basis to ensure both projects are aligned. **Patient self referral (React) –** work is being undertaken in partnership with Prof Ken Muir at the University of Manchester to explore the potential to pilot an online tool for patient self assessment on cancer risk and subsequent self referral. The intention is to undertake a 1 year pilot with the following objectives: ▪ To develop a risk based approach to direct symptom based referral from the community. ▪ To widen access to community based engagement opportunities to pilot the model. ▪ To assess users views and experiences of using the approach. **Digital pathology -** The introduction of digital pathology technology as another aspect of speeding up the diagnostic process is currently being explored within Vanguard Innovation. **Industry Challenge** – due to the success of the Vanguard's Pharma Challenge process, it has been agreed to undertake a further 'Industry Challenge' process with a specific focus on earlier diagnostics and digital solutions. UCLH Vanguard partners are leading on this and will publish a process for undertaking this within the next few weeks. Communications will be sent to Industry partners inviting them to submit proposals for addressing the earlier diagnostic challenge. Vanguard Innovation is also linking with GM AHSN in securing industry support for local innovations. **Partnership working with MCIP** – Vanguard Innovation is committed to aligning with other partners work and this is particularly relevant with MCIP who are also leading on piloting innovations in key areas of cancer services. As part of the earlier diagnosis work stream, Greater Manchester Cancer Vanguard Innovation has been in communication with the Manchester CCG's based Macmillan Cancer Improvement Partnership (MCIP) regarding the innovative approach to lung cancer early diagnosis that they have piloted via United Hospitals of South

	Manchester with the Manchester Thoracic Oncology Centre at UHSM. This has involved use of low dose CT scanning in identified higher risk population groups (smokers, ex-smokers and older people) and early indications are that this may be a highly effective approach in picking up early cancers before the patient shows any significant symptoms and one which has been widely taken up.
Cancer Education (Gateway-C)	A pilot of an education training tool is now underway at 8 GP practices (4 in Wigan / 4 in South Manchester) following a successful show case event held on 13th Dec 16. Initially focussed on lung and colorectal early diagnosis, the tool involves both simulated patient consultations and interactive learning activities. This tool has been endorsed by GM SCN, CRUK and Macmillan and an application for RCGP accreditation is in process. To date, 75% of the GPs in the pilot cohort are now registered and undertaking the online courses. Early feedback has been positive.
Developing standards of care	This is an ambitious project that aims to set challenging standards across key cancer pathways and then measure compliance against these through a locally developed accreditation process. The first pathway chosen is colorectal cancer and rapid progress has been achieved in identifying standards to drive implementation of the 'clauses' described within an Accreditation Framework, recently released by the British Standards Institute (*Healthcare: Provision of clinical services – specification (PAS 1616:2016).* Vanguard Innovation will be working with the BSI and all colorectal clinicians and service leads across GM. A workshop is being planned for March / April 2017 to develop these standards. Local development of a further sub clause focussed on psychological and emotional support has progressed, working with clinicians and patients reps to develop this sub clause which will be included in part of the patient centred care clause within the clinical standards framework. The work in the project will be presented at a Vanguard Show Case event to be held on Tuesday 17th January 2017. 
Living with and beyond cancer	There are 3 projects within this work stream and all centre on the fundamental principle that people affected by cancer must be involved in all aspects of care provided. **1. Aftercare pathways** – work is underway to develop a digital safety net to enable patients post treatment to be followed up in the community and with self management. 2. **Enhanced patient decision making** – this project is led by Prof Janelle Yorke working with the Christie Patient Centred Research Centre. A period of consultative interviews with approximately 40 Oncologists, GPs patients and carers has just been concluded. The Goals of Care tool is in the process of being refined as a consequence of the consultation exercise, and it remains the intention to commence the pilot of the tool at the end of February 2017 at The Christie. 3. **Specialist palliative care** – 3 vanguard partners are working together to develop a consistent survey aimed at collecting data on current service infrastructure. They will work with the APM (Association of Palliative Medicine) and the Royal College of Physicians to develop minimum staffing requirements for 7 day access to specialist palliative cancer care.

Cancer Intelligence	A GM Cancer Vanguard project team is working with colleagues in London and London PHE to establish enhanced cancer intelligence, at a level of granularity that is greater that the PHE national cancer dashboard. A key principle of the work is that there will be a single approach to common elements, for comparison across vanguard sites, complemented by local metrics and analysis. **Cancer Intelligence System metrics** – in taking this work forward, papers for a Project Steering Group inaugural meeting have been drawn up and the following actions achieved: • First metric highlight report drafted for circulation to steering group • PID revised to include 2017/18 milestones and budget • Meeting set up with GM pathway managers (Jan 19th) to review GM appropriate pathway metrics • Workshop set up (Jan 13th) with a Business Intelligence Tool developer (for dashboard build) • Honorary Contracts in place and all training for access to data completed • Analysts progressing on developing data feed for interactive dashboard **PROMS / PREMS tender -** Another element of the cancer intelligence function is enabling the routine collection of PROMS and PREMS information and a tender has recently been completed to identify a lead partner. The pilot of a PROM / PREM system will go live from 1st Feb 2017, providing almost real time access to patient views and issues, fed back to all GM providers involved. Stakeholder meetings have already been held to seek views on how this will be taken forward.
Medicines Optimisation (MO)	The Cancer Vanguard ran a process to secure support and involvement from pharmaceutical partners. This was undertaken in partnership with the Association of British Pharmaceutical Industry (ABPI) and has resulted in 5 schemes being taken forward out of 40 applications received. A national press release has been issued highlighting the success of the Pharma challenge (see Appendix 2) and the signing of joint working agreements with Sandoz (bio-similar education) and Amgen (modelling out of hospital administration of denosumab). The joint Vanguard MO group meets on a monthly basis. Two more PIDs are due to be ratified by GMCVI Steering Group in Jan 17 following which those projects will commence.
Commissioning reform and testing an Accountable Cancer Network (ACN)	GM has been working with RM Partners to develop proposals for how an ACN might work in practice and the benefits it would bring. The core principle for this project is driving improvements in clinical outcomes and patient experience together with the more effective use of cancer resources. A series of stakeholder one to one discussions and group engagement events led by KPMG have tested this work. Papers have been produced regarding the vision and outcomes and the scope of an ACN in GM. Further work is taking place regarding the organisational form and governance options and potential payment mechanisms. A steering group has been established including provider, commissioner and PABC representation. The commissioning work is being aligned with the GM H&SC Partnership review of commissioning and locality plans and is reflected in the GM Cancer Plan.

Other Updates	• **Vanguard Innovation funding allocation** – following national confirmation of funding for 2017/18, a funding allocation event will be held on 12th January 2017. This centres on the Vanguard Innovation Oversight Group receiving updates from all the projects and agreeing how this year's allocation is used to support the continuation of these projects. • **New Care Models Team (NCMT) Quarter 3 review** – this will be held on 18th January 2017. • **National Cancer Vanguard learning day** – this is due to be held on 23rd March and will principally be aimed at sharing learning to date with emergent Cancer Alliances. • **Evaluation tender** – an ITT to secure an academic evaluation partner has been produced and the tender is due for completion in February 2017. • **Joint Delivery Plan** – a single Cancer Vanguard Delivery Plan is being produced in partnership with UCLHCC and RM Partners for 2017/18. Once completed, this will be shared with the GM Cancer Board.

2.0 Issues for consideration by GM Cancer Board

2.1 Communication and engagement in the Vanguard Innovation work

Vanguard innovation has developed a number of ways of engaging and communicating with key stakeholders to share our work as summarised below:

- Bi Monthly bulletin
- Website (www.gmcancervanguard.org)
- Twitter account (@GM_Ca_Vanguard)
- E mail account (cancervanguard.gm@nhs.net)
- Monthly Show case events
    - Tuesday 17th January 2017 – Developing standards of care
    - Tuesday 28th February 2017 – Clinical Information Systems
- Broader stakeholder events (both GM and nationally)
- Vanguard Videos
- Update reports to GM Cancer Board, H&SC Partnership, NCMT quarterly review

GM Cancer Board is asked to advise on any other methods to ensure effective communications and engagement of our work

2.2 Continuation of Vanguard Innovation initiatives after March 2018

The national Cancer Vanguard's funding from the New Care Models Team will cease in March 2018 but it may be that some initiatives commenced during the lifetime of the Vanguard require more time to be fully completed and evaluated before wider dissemination is considered. Furthermore, there will be a need for additional new innovations to be identified and supported after this period.

GM Cancer Board is asked to advise how current innovations will be progressed and future innovations will be identified and funded once the formal National Cancer Vanguard is completed.

3.0 ACTION REQUIRED

The Greater Manchester Cancer Board is asked to note the progress update on Vanguard Innovation and advise of any issues.

Jenny Scott
Programme Director
Vanguard Innovation

20th January 2017

APPENDICES – SEE SEPARATE PDFs

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number 7

Greater Manchester Cancer

Modernising Radiotherapy Services in England – developing proposals for future service models

Please find attached the response to the consultation 'Modernising Radiotherapy Services in England' on behalf of the Greater Manchester Cancer Board. This is a collective response and as such represents the agreed view of all GM commissioners and providers.

The table below sets out our detailed responses to each of the eight recommendations.

	Recommendation / Proposal	Greater Manchester Response
1	The adoption of a mechanism for partnership working between radiotherapy providers, networked across a geographical population footprint of 3 to 6 million, designed to underpin	We would support this proposal. This configuration is already in place in Greater Manchester and Cheshire and The Christie receives referrals from part of Lancashire
2	That each "networked non-surgical clinical oncology service" configuration would include at least one tertiary centre and / or a tertiary centre that closely fulfils the definition of a comprehensive cancer network to lead the new service.	We would support the proposal that each network includes a tertiary radiotherapy centre. The Christie is the lead provider of radiotherapy and the tertiary radiotherapy centre serving the whole of the conurbation.
3	This means that the lead provider should host the full range of specialist MDTs in line with tumour specific Improving Outcomes Guidance including population size and patient numbers for the full range of cancers including rare cancer specialist MDTs (sarcoma, neuro-oncology, paediatric oncology, hepato-biliary and pancreatic cancers etc) and must be a specialist regional provider of radiotherapy, treating a large range of cancer sub-site specialisations.	We do not see the rationale for this or indeed how it follows from the case for change or fits with the other proposals made in the document. This is particularly the case where, as in Greater Manchester, radiotherapy is provided by a specialist, largely non-surgical, oncology provider and cancer surgery is largely provided in specialist surgical hospitals. GM has established sMDT arrangements in place for the vast majority of tumour groups and advanced plans in place for the remainder. Our arrangements place the hosting of the sMDT with the most appropriate organisation reflecting the clinical service model. We do not support nor envisage moving to an arrangement whereby the radiotherapy lead provider hosts the range of sMDTs as outlined in the consultation document. As proposed national guidance, the recommendations must be relevant for all of England and therefore cannot be based on a configuration

		that is appropriate for some parts of the country but not others.
4	The approach, described above, would be encapsulated through a networked non-surgical oncology provider Board, led by the lead provider. The Board would agree the structure and configuration of service delivery and underpinned by formal governance and contractual arrangements. The Board will include equal and balanced multi-disciplinary representation and decision making from all providers comprising the networked non-surgical clinical oncology service. In addition, each Board will have whole system representation, in particular senior leader(s) from the relevant Cancer Vanguard or Cancer Alliance, ensuring a link to Clinical Commissioning Groups, and Sustainability and Transformation (STP) groupings.	We would support this recommendation although this should be a 'provider board' (not have whole system representation as described) and report in to a system board that has whole system representation and responsibility.
5	The models must be underpinned by a single, integrated, multiprofessional team that is co-ordinated to provide the designated range of radiotherapy treatments (as determined by the Board) from each of the delivery sites within the networked geography. The working arrangements should not be seen as hierarchical but rather harnessing the expertise that already exists across provider organisations within the "networked" service.	We would support this recommendation
6	That the process of equipment modernisation must be linked to the implementation of the service and clinical models (over time) to ensure value for money, facilitate efficiency gains and optimise the use of equipment and achieve the ultimate goal of improved patient care standards and outcomes.	We would support this recommendation, although it must be part of the overall capital plans for the cancer system
7	That investment is also made in IT infrastructure and electronic links between networked non-surgical oncology providers. This will enable	We would support this recommendation, although it must be part of the overall IT plans for the cancer system

	innovative team approaches in treatment planning as well as facilitating regular interdepartmental quality assurance.	
8	A move towards common protocols, integration of a quality assurance framework and common Standing Operating Procedures is adopted……..	We would support this recommendation

Attached is our response to the specific consultation questions.

We hope that you find these comments helpful. If you require any further detail, please do not hesitate to contact the officers of this board.

Greater Manchester Cancer Board

Question 1a: Do you support the proposal to create networked services?

Yes – this reflects the configuration that we already have in place in Greater Manchester and Cheshire system.

Although 7 day services are mentioned at start there seems to be no indication of the rationale or expectations on how this might develop beyond a minimum of 5 treatment days per machine each week

Question 1b: What comments and/or ideas do you have about how networked services could be organised?

Already achieved in Greater Manchester and Cheshire (GM&C) system

Potential to broaden the footprint of the specialist RT centre for GM&C with a 3rd satellite, and broader integration within Lancashire and Merseyside.

Question 2: What comments and/ or ideas do you have about how the proposals could work in practice?

The specialist RT centre for GM&C has a successful, mature, rolling replacement programme for XRT, including investment at satellite centres.

Question 3a: Please explain whether you feel that the case numbers presented within the clinical and service model reflect clinical best practice?

Yes, it reflects best practice.

Question 3b: Can you think of anything else that should be considered that may impact on the case numbers proposed?

Rare cancer treatments on a wider geographical footprint, networking across a number of alliances

Question 4a: What equality and/or health inequality issues may arise as a result of the proposals, as they currently stand?

Urban versus rural provision, transport and localisation of services

Question 4b: What steps could be taken to avoid any equality and/or health inequality issues?

Satellite service provision, through a network alliance solution

Question 5: Is there anything else that we need to take into account when developing the service specification?

Engagement with stakeholders