GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Agenda

Meeting time and date: 8.00am-10am Friday 18th January 2019

Venue: Frank Rifkin lecture theatre, Mayo Building, SRFT.

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	
3	Action log and matters arising	Paper 1	Note	Richard Preece	
4	Update from GM Cancer User Involvement Steering Group	Verbal	Note	Nabila Farooq Ian Clayton	10′
5	GM Cancer Plan Progress to date ▪ General Plan ▪ Prority1 projects	Paper 2 Presentation	Discuss	Claire O'Rourke	15'
6	Update on the NHS Long term plan on Cancer and impact in GM	Presentation	Discuss	Roger Spencer	15'
7	Cancer workshop: summary document and outcomes	Paper 3		Rob Bellingham	15'
8	Palliative and End of Life Care Framework and Objectives	Paper 4/ Presentation	Discuss	David Waterman & Anne Marie Raftery	15'
9	GM ACE Wave 2 Pilot Project: The development of Multidisciplinary Diagnostic Centres (MDC) to improve the outcomes of patients with vague symptoms	Paper 5/ presentation	Discuss	Sarah Taylor/ Richard Jones/ Sue Sykes	20'
10	Transformation Project Update: CURE project	presentation	Note	Matt Evison	15'
11	Papers for information: ▪ GM cancer conference feedback ▪ NHS 10 year plan documents		Note Note	Dave Shackley Dave Shackley	5' 5'
12	Future Meeting Dates: ▪ **8th March 2019:** 8-10am ▪ **3rd May 2019:** 8-10am ▪ **12th July 2019:** 8-10am ▪ **13th September 2019** 8-10am				

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Paper number 1

Minutes of Greater Manchester Cancer Board

Time & date: **8.00am-10.00am Friday 2nd November 2018**

Venue: **Humphrey Booth Lecture Theatre, Mayo Building, SRFT.**

Chair: **Richard Preece (8-8:50am) & Dave Shackley (8:50-10am)**

GM Health & Social Care Partnership Team		Richard Preece	RPre	Executive Lead for Quality, GMHSC Partnership (Chair)
Medical Director - GM Cancer		David Shackley	DS	Medical Director, Greater Manchester Cancer
AGG of CCGs		Rob Bellingham	RB	Director of AGG of CCGs
Director of Commissioning – GM Cancer		Adrian Hackney	AH	Director of Commissioning – GM Cancer, NHS Trafford CCG
Provider Trusts	Salford	Jack Sharp	JS	Director of Strategy
	Manchester FT	Darren Banks	JW	Director of Strategy
	The Christie	Roger Spencer Chris Harrison	RS CH	Chief Executive Medical Director
	Stockport FT	Colin Wasson	CW	Medical Director
GM Health & Social Care Partnership		Janet Butterworth	JB	Assurance & Delivery
Director of operations group		Fiona Noden	FN	Director of Operations
People effected by Cancer		Ian Clayton	IC	User representative
People affected by Cancer		Nabila Farook	NF	User representative
User Involvement GM Cancer		Sarah Howarth	SH	Macmillan User Involvement Programme Manager
GM Health & Social Care Partnership		Tracey Vell	TV	GP Lead
Nursing Leadership		Sue Ward (Deputy for Cheryl Lenney)	SW	Deputy Director of Nursing, MFT
Christie School on Oncology		Cathy Heaven	CH	Associate Director, Christie SoO
GM Cancer		Claire O'Rourke	CoR	Associate Director, GM Cancer
GM PH Transformation		Siobhan Farmer (Deputy for Jane Pilkington)	JP	Public Health Consultant
Macmillan Cancer		Tanya Humphreys	TH	Macmillan Interim Head of Services

			North West of England

In attendance

Skin Pathway Board Update	John Lear	JL	Clinical Director GM Cancer Skin Pathway Board
Single Surgery Cancer Models – Programme Implementation Update	Sarah Maynard-Walker Kate Rogerson	SMW KR	Programme Director NHS Transformation Unit Project Manager NHS Transformation Unit
62 day: Cancer referral increase in GM	Susi Penney	SP	Associate Medical Director, GM Cancer
Genomics in GM & Pathway Board update	Fiona Blackhall	FB	Clinical Director GM Cancer Genomics Board
GM Cancer	Rachel Allen	RA	GM Cancer
	Michelle Leach	ML	GM Cancer
	Fiona Lewis	FL	GM Cancer
	Johnny Hirst	JH	GM Cancer
	Zoe Merchant	ZM	GM Cancer
	Alison Armstrong	AL	GM Cancer
	Ryan Donaghey	RD	Provider Federation Board
	Catherine Perry	CP	University of Manchester-RESPECT 21

1. **Welcome and apologies**

RPre welcomed all to the meeting and noted the apologies received. He then invited the participants to provide introductions. RPre gave congratulations to RS for the Christie's outstanding CQC outcome; RS replied he was happy to receive the congratulations on behalf of the team at the Christie and all its partners who made it possible. RPre explained that the 62-day performance of the cancer system will be manged at the Performance and Delivery Board not at this meeting for the groups information.

2. **Minutes of the Last meeting**

These were accepted as a true record.

3. **Action Log and Matters Arising**

No none agenda items raised on the action log.

4. **Update from GM Cancer User Involvement Steering Group**

IC updated the board as follows:

- The User Involvement (UI)Team are working with pathway boards to agree priorities for UI input and the impact this makes, The service user representatives and UI Managers are working with Pathway Directors to ascertain how the service users input into the top 3 deliverables i.e. MDT reform, 62 day figures and the Recovery Package.
- SH is leaving the team and will not to be replaced; however there will be a full time replacement for the Team Leader Lucie Francis whilst she is on maternity leave and another full time UI Manager and UI co-ordinator to replace Wendy Chapman.
- There will be a UI away day on Saturday 3rd November with approx. 30 people from the programme attending. The day will be updating the service users on the GM Cancer work programmes.

- There will be a commissioning workshop to share understanding about the present position in relation to the commissioning of cancer services and pathways across GM on the 16th November which IC will be attending along with 3 other PABC.

5. Skin Cancer Pathway Board Update

John Lear the Pathway Director of the Skin Pathway Board spoke about the tabled paper and presented on the developments in the skin cancer pathway. The number of patients referred with suspected skin cancer is increasing year on year by approx. 10% which is challenging and also having a subsequent adverse effect on patients with other inflammatory skin conditions and the services that provide this.

He highlighted the work being done on a referral pilot project to triage patient referrals, assisted by a digital platform that enables GPs to transmit normal photos and dermatoscopic photos to Dermatologists. IC commented that he was pleased with advances being made. Discussion ensued about what a dermatascope is and the costs involved. TV suggested that it could include more data on late referrals or missed skin cancers and highlighted that we need to collaborate with the GP community more and end silo working. CH said it would be important to link up with the Gateway C team as a model is already developed for GP Education and her team would be happy to work with him. RPre thanked John for his update on behalf of the Board.

Actions: RP asked John Lear to convene a team of relevant stakeholders to move the pilot forward and DS and the GM Cancer Team would help support that. John Lear to contact CH re Gateway C.

6. Genomics in GM and Pathway Board Update

Fiona Blackhall (FB) presented an update on the Genomics Pathway Board. The objective of the Genomics PB is to lead the adoption of genomic medicine in cancer pathways across Greater Manchester.

She went on to explain that there will be 7 national Genomics laboratory hubs of which the NW Genomic Laboratory Hub will led by MFT. She spoke to the proposed engagement plan and how genomic tests will be commissioned.

FB explained that Manchester is currently ranking at number 8 in the UK in the 100K Genome Project which GM is hoping to improve on. RPre commented that the figures for collection of samples for 100k were not as high as we would have liked and FB concurred. GM was slow to gather momentum on the project but is now acquiring samples at a reasonable and agreed rate. In the near future it is expected that the 10 year national NHS plan will state a drive to acquire 5 million genomes especially in cancer over the next few years and FB presented a plan on how the Genomics Board intend to drive the performance in this area.

RP commented that it is good news for the team in Manchester who worked on Manchester becoming the hub for the North West. RS explained that the advantage Manchester has on the National stage is that GM colleagues like Fiona have experience in using sequencing information to change treatments for patients which can have a massive impact for the future treatment of our patients in GM. DB stated that some of the successful assets in the NW Hub do not reside in Manchester; this is being looked at by the NW partnership Board to include the contracting and finance part of this work. RPre thanked Fiona for her presentation.

7. 62 day: Cancer referral increase in GM

SP present the circulated paper to the group. She explained that GM has failed the 62 day targets for the first time as a whole in quarter 1 and early indications are we will fail in quarter 2. She explained that moving forward we will need to diagnose more patients earlier and we cannot deal with current demand. SP explained that a capacity and demand exercise is underway in diagnostics and spoke about there being a diagnostic capacity dashboard moving forward so we can be transparent about our wait times. DS explained to the group that this diagnostic shortage is not just a cancer issue but across the system.

IC asked if performance management is being handled elsewhere (performance and delivery board) can the UI team have those minutes – JB to action. He also commented that 62 days is an unacceptable target in the first place; ask your family what they think regarding treatment times and you will get answers around the 7 day mark. He went on to challenge the group that the view on these targets is too introspective the data constantly compares Manchester to Manchester, the cancer plan says we want to become world class so we should compare to other countries. DS said that some work is underway to look at some international partners but they cannot currently give the answers as there is nothing yet set up to provide this. IC asked can the board request the informatics team start looking at this. DS and CoR to look at this moving forward.

Actions: JB to ensure the Performance and Delivery Board minutes are circulated to the UI Team
DS & CoR to work with the Informatics team to look at international data collection (but accepting that this depends on availability of data from international partners)

8. GM Single Surgery Cancer Models – Programme Implementation Update

The Board welcomed Sarah Maynard Walker back to update on the progress over the past 6 months. Sarah presented the highlights from the tabled paper.
OG- single service went live 1st September 2018. There is a new on call service, MDT and clinics at MRI and Wythenshawe and capacity increased at SRFT. Next steps are moving the project to business as usual to include new contracting arrangements.

Urology - The first joint clinic started in Oldham in August with Pennine Patients now receiving robotic prostectomy at The Christie. Open Kidney and Bladder operations are moving to Wythenshawe. There has been a consensus reached on SMDT and a skill based on call rota. MFT and the Christie project teams are working well together. Moving forward they will be working on further engagement , benign “hot sites”, HR working group and a joint approach for the procurement of robotic consumables.

Gynaecology– Key achievements include the appointment of a clinical lead, single research policy, policy for the equitable use of the Christie robot, external advisory panels and Gynae SMDT to be the pilot for MDT reform. The milestone plan has been revised with the SMDT timed to go live in April 2019 with an incremental approach. She went on to explain the challenges the main challenge on time to the clinicians who do this alongside their day job.
SH gave feedback that the UI Steering Group would like to see more information on engagement and also can there be UI input in the urology work. Sarah explained that they do have engagement from their own patient panel but will link with SH moving forward. RS reiterated the importance of patient involvement in every step of this transformation work. FN reminded the group that this work is very complex and has been 17 years in the making so had progressed really well in the last 2 years.

Sarah spoke about the branding for these single service models and asked the board if they had any advice on this. DB said there is great benefit that transcends organisations but we need to be mindful that we also cover part of Cheshire and need to be inclusive. Discussion ensued around branding and there was a strong feeling that the service is delivered in GM and should be branded as such.

Action: Sarah Maynard Walker to work with SH to broaden the involvement of service users in the transformation work, and to consider 'GM' being used to describe the new single services.

9. Papers/ updates for information

I. DIEP service update

DB spoke to the tabled paper to provide the GM Cancer Board with a summary of the actions taken in response to demand and capacity constraints at Wythenshawe Hospital for the Deep Inferior Epigastric Perforator (DIEP) Flap service. In summary, the restriction of the service has been required in order to manage the demand whilst additional capacity can be put in place to tackle the current waiting times, reduce the waiting list, and provides future proofing of the service to ensure demand and capacity are aligned. The paper outlines the actions being taken with progress already made to increase the workforce and reduce the 52 week waits in line with the national requirements. Unfortunately there is not the capacity to treat every woman who might want to receive this treatment in a timely manner. RS said that this example of where we should have GM wide commissioning. AH said that there is also a people resource issue in this instance not just a commissioning issue.

II. GM Cancer Conference

DS reiterated the details of the upcoming Cancer Conference and encouraged attendance.
Actions: Update to be provided at the next GM Cancer Board

III. Commissioning Workshop

DS explained about the commissioning workshop on the 16th November and encouraged attendance from anyone who thinks they can add value to this meeting.

Actions: Update to be provided at the next GM Cancer Board

IV. Priority 1 Projects & the GM Cancer plan

There will be a formal update at future boards led by the new Programme Lead Alison Armstrong. CoR updated the group on the 8 key projects and explained that we will be recruiting the personnel for these projects in the next couple of months.
Actions: Detailed Update to be provided at the next GM Cancer Board with update on active projects and progress against the stated GM Cancer plan at every cancer board

V. NHS 10 year plan – cancer element

RS explained that cancer and mental health will be a priority. There will be a new research network, stratified testing, precision treatments, transformation of follow up using digital and community based follow up. GM needs to look at how we align our GM Cancer plan with this.
Actions: Update to be provided at the next GM Cancer Board with the opportunity to discuss how the national plan would dovetail with the GM cancer plan

10. Future Meeting Dates

DATE	TIME	VENUE
08/03/19	8-10am	HBLT, SRFT
03/05/19	8-10am	HBLT, SRFT
12/07/19	8-10am	HBLT, SRFT
13/09/19	8-10am	HBLT, SRFT
01/11/19	8-10am	HBLT, SRFT

Action log

Prepared for the 18th January meeting of the board

	ACTION	AGREED ON	STATUS
1	RP asked John Lear to convene a team of relevant stakeholders to move the pilot forward. John Lear to contact CH re Gateway C.	2nd November	Completed.
2	JB to ensure the Performance and Delivery Board minutes are circulated to the UI Team	2nd November	To review.
3	TU team to ensure wider involvement of UI team and patients in surgical transformation work	2nd November	Completed.
4	Papers of information: request for update on: • Update on GM Cancer Conference • Commissioning workshop • Priority 1 projects • NHS 10 year plan	2nd November	On agenda.

Paper number **2**

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	18th January 2018	
Title of paper:	GM Cancer Plan Review and transformation funded priority 1 projects update.	
Purpose of the paper:	To update the GM cancer board on progress against the GM cancer plan since publication in February 2017 and update on priority 1 projects.	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	✓	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes	The paper will aim to update the board on the progress of the implementation of the GM Cancer Plan, indicating 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.	
Reducing inequality	The delivery of the GM cancer plan is heavily predicated cancer provision ion GM demonstrating a reduction in inequality across the system.	
Minimising variation	As improved outcomes above.	
Operational / financial efficiency	The financial on operational impacts of the plan has been detailed through the GM cancer board and the Transformation funded projects as described	
Author of paper and contact details	**Name:** Claire O'Rourke **Title:** Associate Director, Greater Manchester Cancer **Email:** claire.orourke@christie.nhs.uk	

Greater Manchester Cancer Board

Date: **18th January 2019**

Title: **GM Cancer Plan Review and Transformation funded projects overview**

From: **Dave Shackley, Medical Director GM Cancer**
Claire O'Rourke, Associate Director, GM Cancer

1. Purpose of paper

This paper is to provide the GM cancer board with an update of progression against delivery of the GM cancer plan (as of January 2019) detailed as:

- **Section 1**: **Key work streams which have been fully delivered**
- **Section 2a**: **Key work streams In progress**
- **Section 2b: New work streams and projects (identified as national priorities and priorities for GM)**
- **Section 3: Key work streams not under development**

This paper will also detail an update on delivery of the agreed ***priority 1 projects*** for the transformation of cancer services in GM. All priority 1 projects are aligned with the key ambitions of work outlined in the GM cancer plan:
https://gmcancerorguk.files.wordpress.com/2016/08/achieving-world-class-cancer-outcomes-in-gm-v1-0-final-02-2017.pdf.
The priority 1 projects were agreed in September 2018, following allocation of a £10m investment from the GM transformation fund (over 3 years).

2. Introduction

In Feb 2017, *the GM Cancer Plan* was formally agreed at the Strategic Partnership Board, representing the cancer priorities/ plans to be delivered by March 2021. Explicit in this was the need for the GM system to work together on funding and implementing the plans with a variety of stakeholders leading on different projects.

At the GM Cancer Workshop of November 2018, it was agreed that a 'rapid review' was undertaken to see which elements of the programme had been delivered, and which were still in progress.

It has been acknowledged in the November workshop that the GM Cancer Plan 2017-21 represented the GM priorities drawn from the then National Cancer Strategy, with some plan objectives describing only preparatory work.

Two years into the plan we can now see that there are some new additional themes of work that flow from the original plans/ ambitions and these areas are set out in section 2b, alongside newer national priorities that have been published.

As we move forwards, a closer integration between cancer services with education/ information (patient related and professional level) and especially research has become more critical to future improvement – this would be exemplified for example in the field of cancer genomics which is advancing at a rapid rate not entirely foreseen even 2 years ago. Genomics, only briefly mentioned in the 2017-21 plans, will become pivotal in the very near future.

It is also worth referencing that much of the cancer work that happens within GM lies alongside and in parallel with this cancer plan such as pathway board improvement work, 62d issues, and working with national and alliance partners in developing and facilitating cancer improvement on a wider footing. Outlined below are the key objectives of the GM cancer plan of which all programmes of work are aligned:

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 delivery of the GM cancer plan has been achieved under eight domains, detailed below. The domains reflect a combination of the five key areas for change set out in the GM cancer plan on behalf of the devolved health and social care and the six key work streams of the national cancer strategy. Four domains cover the four broad parts of the cancer pathway. The remaining four are cross-cutting areas. The domains are set out in the figure below:

Progress against the GM Cancer plan (January 2019):

1. **Section 1 –** GM Cancer Plan objectives that have been **FULLY DELIVERED:**

➢ Prevention:

- GM Population Health Plan agreed with implementation commenced.
- GM Tobacco Control Plan agreed with implementation commenced.
- Bisphosphonates to reduce post-menopausal breast cancer recurrence.
- Initiate a citizen-led 'cancer champions' social movement.

➢ Earlier Diagnosis:

- Assess/ develop plans following completion MCIP lung health check project
- Primary care education and support to fully implement the national NICE 2015 updated suspected cancer referral guidelines
- Support/ deliver on 'Be Clear on Cancer' campaigns
- Health equity profiling/ population segmentation re screening
- Randomised trials evaluating behavioural insights and differing screening letters to see if wording and presentation of letters affects uptake
- Roll out standardised urgent cancer GP referral forms across all GP practices with audit demonstrating comprehensive coverage
- Pilot 'non-specific but concerning' symptom assessment clinics (ACE 2)
- Pilot 'faster pathways' (achieving the faster diagnostic standard) as part of the National Cancer Vanguard (cancer yes/ no within 28 days)
- The GM Haematological Cancer Diagnostic service (HCDP) went live Nov 2018
- Piloted straight-to-test colonoscopy in suspected bowel cancer
- Developed & agreed standardised diagnostic pathways for colorectal, lung and prostate cancer (incl adoption nationally via NHSE planning guidance 2018)
- Developed and agreed standardised diagnostic pathway for oesophago-gastric cancer
- Breast cancer services audit of 'one stop' services
- Radiological workshop on planning a new GM-PACS and networked radiological reporting service

➢ Improved & Standardised Care:

- Oesophago-gastric cancer single surgical service agreed, implemented with service going live September 2018 with all complex surgery performed on a single surgical site for GM (largest centre in Western Europe)
- Urology cancer surgical reconfiguration: service specifications agreed, model agreed; implementation plan agreed
- System in place to report 62d, average and range of waiting times for all cancer pathways in all providers/ all CCG's
- Agreed the 4 highest priority pathways for cancer diagnostic reform, alongside National Vanguard & NHSE partners as lung, colorectal, prostate and oesophago-gastric cancer
- Reviewed and strengthened pathway boards with formal annual panel review (including service users), a formalised yearly annual plan, robust GP / patient involvement & a rolling programme of GMCB presentations
- Proton Beam Centre formal opening
- All HPB cancer surgical patients have access to a prehab programme
- Over 1000 GM cancer patients recruited to national 100,000 genomes project

➢ Living with and Beyond Cancer:

- Standardised approach to recovery package
- Standardised pathways for stratified follow up agreed for breast, prostate and colorectal cancer (implementation in progress)
- Goal of Care tool –aka 'CAN-guide' (shared decision making in advanced disease) piloted
- Psychological clinical group formalised as a 'pathway' board
- Consequences of treatment mapped by pathway with a gap analysis
- Enhanced supportive care clinics piloted and now instituted at Christie
- Palliative care services across GM mapped against national standards and competencies with gap analysis by provider/ CCG
- Economic & clinical/ service modelling of various options to deliver face to face palliative care services 7d per week in hospices and providers across GM
- Contribution to the 'Dying Matters' events

➢ Patient Experience:

- Leadership defined for GM-level cancer patient experience
- Process for analysing and reviewing performance in the annual National Cancer Patient Experience Survey, including looking at regional (GM) level against comparable areas
- Embed user involvement in all facets of GM Cancer
- Secure future funding for the service users and support team involved with GM Cancer
- Workforce audit in cancer nurse specialists (& 6 other pressured areas) working with HEE to understand the future pressures

➢ Education:

- Agreed a GM-level cancer education strategy (& board/ team to oversee)
- Piloted GATEWAY C modules

- Launched GATEWAY C in GM, developing further modules
- Pathway boards all have an annual educational event

2. Section 2a – GM Cancer Plan objectives that are **IN PROGRESS:**

➢ Prevention:

- Citizen-led social movement – 'sign up' 20,000 cancer champions
- Develop a specific plan to significantly improve HPV vaccination within school aged girls
- Implement a HPV vaccination plan for boys if & when this is formally adopted by the national immunisation programme (agreed 2018)
- Deliver model of lifestyle-based secondary prevention as part of new after care pathways (part of new stratified follow up, ERAS + and recovery package/ health & wellbeing events)
- Aromatase inhibitors (anastrazole) offered to untreated post-menopausal women at high risk of breast cancer

➢ Earlier Diagnosis:

- FIT: replacing FOB in bowel cancer screening – going live 2019
- HPV testing in cervical screening programme for all women
- Bowel scope programme for 55y olds in place by 2020
- Regional fast track jaundice pathway offer for all GM patients
- Roll out of lung cancer optimal (accelerated) diagnostic pathway
- Roll out of prostate cancer optimal (accelerated) diagnostic pathway
- Roll out of colorectal cancer optimal (accelerated) diagnostic pathway
- Pilot streamlined oesophago-gastric cancer diagnostic pathway
- Implement standardised approach to one-stop unexplained vaginal bleeding clinics
- Develop sector based (x4) MDT's in colorectal cancer across GM as per Healthier Together plans
- Proposal for developing networking in cellular pathology services (for subspecialist reporting/ service support/ sharing resources; inevitably aided by digital pathology functionality)

➢ Improved & Standardised Care:

- Deliver the urology single surgical service transformation project with single surgical sites for prostate, renal and radical bladder cancer surgery
- Agree GM model of care & GM service specification for breast services
- Comprehensive review of MDT processes across GM
- Pilot innovative MDT models
- Develop pathway specific GM service specifications for all tumour types over time (urology/ OG complete; breast/ gynae/ colorectal underway)
- Testing of broader adoption of prehab and ERAS + programmes in major cancer surgery beyond HPB and in other forms of treatment in selected cancer pathways
- SACT: Increase chemotherapy delivered closer to home (aim of >80% within 20 mins drive)
- Acute Oncology: Agree a commissioning plan, and delivery of agreed model for a GM integrated service

➢ Living with and Beyond Cancer:

- All patients to receive a care plan based on information including the holistic needs assessment
- Health and wellbeing events in place for initially all appropriate breast, colorectal and prostate cancer patients, followed later for patients with other cancer conditions
- Full recovery package for all appropriate patients reaching completion of treatment
- Stratified follow up to be fully implemented for all appropriate breast, prostate and colorectal patients with pilots in other cancer pathways
- CAN-guide (shared decision making tool in advanced disease) evaluated further and extended to other sites
- Funded plan for increased patient access to psychological support
- Lymphoedema: develop service specifications and proposed model for a sustainable GM service
- Action plan to address any gaps in support for consequences of treatment
- NW end of life care model to be implemented
- Training programme for all staff involved with end of life care
- Access to shared digital palliative and end of life care records with full use in GM (ePaCCS)

➢ Patient Experience:

- On-going cancer intelligence reports and analytical function Patient Experience
- Patient experience group to meet and oversee a system-wide patient experience action plan

➢ Education:

- Gateway C module development
- Coordinated cancer educational programme for (i) social care, (ii) communication training & (iii) patient experience training.

3. Section 2b – GM Cancer Plan objectives that are **IN PROGRESS** and have developed **directly from pilot projects within the plan/ new agreed priorities/ new national planning guidance*/ New NICE guidance****

➢ Prevention:

- CURE secondary care tobacco control project

➢ Earlier Diagnosis:

- Lung Health Checks (lung cancer screening programme) endorsed by NHSE and contained in planning guidance to be commenced in high risk populations*

- Vague but concerning symptom clinics to be expanded from the pilot phase & offered more widely under rapid Diagnostic model/ clinics.
- Commission sufficient capacity to ensure >85% patients meet the 62d standard, identifying diagnostic capacity gaps in 2018/19 and develop productivity plans to close the gaps*
- Delivering the Faster diagnostic standard (cancer yes/ no decision relayed to patient) by day 28 by 2020*
- Piloting streamlined ways of referring straight to specialist units in suspected cancer without seeing the GP.

➢ Improved & Standardised Care:

- Genomics cancer pathway leadership & board agreed during the (successful) bidding process for the NW genomic laboratory hub at MFT. To provide guidance, support and other assistance to the system in embedding genomics into everyday practice including increased cross over with research opportunities
- Gynaecological cancer surgery single service development with implementation plan following new MDT arrangements and a new GM commissioning service specification
- Breast service model (reconfiguration) implemented
- SACT: Increased trial recruitment (research opportunities) closer to home (i.e. outside the Christie site)
- All patients have access to Cancer Nurse Specialist*
- Offer genetic testing for BRCA1 and BRCA2 mutations to all women under 50y with triple negative breast cancer, including those with no family history of breast or ovarian cancer**
- Offer Lynch syndrome testing for all patients with newly diagnosed bowel cancer. Lynch syndrome accounts for 3% of all colorectal cancers (approx. 50 bowel cancer case per year across GM will have Lynch syndrome)**

➢ Living with and Beyond Cancer:

- Macmillan Cancer support funded 7d face-to-face access to palliative care advice – 2 models being tested in 2 localities with detailed analysis of costs and outcomes. Subsequent commissioning decision on next steps for GM after pilot

➢ Commissioning:

- Develop an effective way of making commissioning decisions in a timely way, for GM-level cancer services, working with the reformed JCB and other GM H&SC governance groups
- Formalise and communicate a set of agreed GM standards (planning guidance for cancer) that localities can utilise to deliver locally funded cancer services to the same standard whilst retaining some flexibility on how it is delivered locally
- Standardise the GM approach of (i) cancer peer review of Providers, and (ii) of reporting delivery against agreed standards at locality level

4. **Section 3 –** GM Cancer Plan objectives that are not currently being actively pursued **(preparatory work has been completed).**

➢ Prevention:

- Online tool for assessment of individual risk of cancer available for the public earlier diagnosis
- Roll out to community based staff (pharmacists etc) the ability to directly refer (using 2 week wait referral forms) for investigation of suspected cancer

➢ Commissioning:

- Agree plan for an accountable cancer network with agreed proposals on alternative budgeting, payment and contracting mechanisms for cancer

➢ Patient Experience

- Pilot of real time patient experience to be reviewed.

5. Summary:

There has been significant progress made against the GM cancer plan agree in 2017, which has only been delivered due to the support by our well established, robust cancer system in GM and our patients affected by Cancer.
The GM Cancer team has been leaded this on behalf of the system and as the nominated GM Cancer alliance. Due to the continual change nationally of the Cancer agenda, new work streams and projects have developed since the inception of the GM cancer plan, but the GM cancer system has responded to this and the plan has been adapted accordingly.
With the advent of the new 10 year NHS plan (January 2019), of which Cancer is a key focus, further programmes of work will need to be added to align our GM cancer plan with national ambitions. GM will be expected to lead the way nationally as already demonstrated over the last 2 years. This will require considerable commitment from the entire cancer system in GM, but as a well-established system, there is strong evidence this will be achieved.

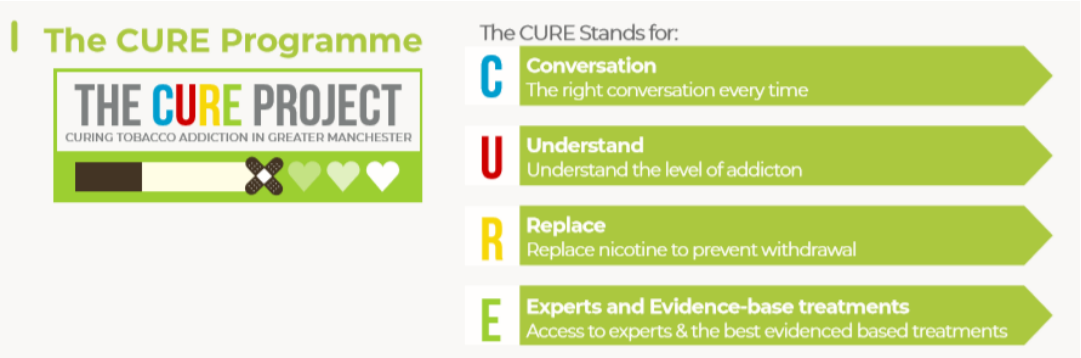
6. Outline Summary of Priority 1 Projects in GM Cancer Transformation funding Plan 18/19

There are ***7 key projects*** focused within the GM cancer phase 1 transformation funded bid, all are aligned with the ambitions above, from the 108 projects detailed within the GM cancer plan. The phase 1 projects are:

1. ***Accelerated pathways: in LUNG, PROSTATE AND COLORECTAL*** which will ensure patients are seen, diagnosed and treated on best timed pathways in 28 days. This is aligned with NHS England national priorities and supports delivery of the 62 day cancer standard in GM and will improve further, 1 year survival rates.

2. ***Supporting cancer patients before and after treatment***: Pre-habilitation, enhanced recovery after surgery (ERAS) and recovery package will ensure 1,000 patients are offered an innovative prehabilation and exercise programme in GM. This will dovetail with the implementation of the recovery package for all patients in GM.

3. ***The CURE Programme***: CURE (detailed below) will deliver a comprehensive tobacco addiction treatment service for all inpatients within acute care trusts, aligned to save lives and reduce smoking rates in GM. This is now a key strategic component of the newly published NHS 10 year plan and GM has led the way in the development of this service and GM will be the first place in the UK to roll out this plan.



4. ***Stratified Follow up***. This approach will reduce the demand for routine follow up and release capacity to address the expected increase in cancer referrals patient. Evidence from the vanguard pilot identified that 68% of patients on the new breast aftercare programme were assessed as suitable for self-management. This project will focus on stratified follow up in breast patients only in the first instance. This programme of work has significant impact on the patient experience; previous work having shown that 95% were satisfied with their new 'moving on' appointments.

5. ***Cancer Intelligence.*** The GM Cancer Intelligence Service (CIS) will provide GM Cancer, commissioners, providers and GPs access to the most current and detailed performance, outcomes and patient experience data, in order to help support cancer services. This service will also provide access to meaningful data for patients to help better inform them of choices related to their cancer care thus supporting all of the phase 1 projects.

6. ***The Cancer Education*** project will work with all stakeholders across the GMHSCP (in health & social, voluntary, charitable and community) to create a single, agreed, educational vision for cancer workforce development and a single service framework for

cancer education, as a trailblazer for the NHS nationally and supporting the delivery of phase 1 projects.

7. ***Shared Decision Making.*** Use of the CANGUIDE tools will facilitate a person-centered approach by supporting patients to communicate their personal goals and preferences to clinicians, working in partnership to choose the best course of action for them in relation to their treatment options. The aim being to help streamline the patient's care; the tool can then be shared between oncology teams, GPs and patients, and can be revisited over time.

1.2 Summary of delivery of key projects September-Dec 2018

Three key projects are already underway following agreement of the transformation funding and its financial transaction in ***September 2018*****.**

CURE:

- The Clinical Lead and Project Manager posts have been recruited to and are in post; full recruitment of all posts aligned to this project will be completed by March 2019.
- The first site chosen for roll out was MFT (**Wythenshawe)** and the project commenced in October 2018. Already in the first few weeks there are already high numbers of patients being supported and the clinician/nurse training is complete. Already 900 patients have been supported by CURE and 380 patients have quit smoking as a result. The GP response to the programme has been very supportive and the clinical teams at MFT have embraced
- Further primary care engagement and community links identified across GM has been established
- Scoping of existing acute care service is complete- 6 provider sites agreed for roll out in early 18/19
- Plan agreed for funding and baseline data collection with project support having been identified.
- Initial evaluation from phase 1 (Wythenshawe Hospital) complete and key learning shared.

Pre-habilitation:

- Recruitment to the Project Manager and Clinical Lead were completed in September 2019 and both well established in post.
- This project is currently in its scoping phase. The project team have held successful preliminary workshops with the lung & upper GI pathways with a colorectal workshop in December 2018. These workshops were aimed at presenting the programme and presenting evidence to MDTs of prehabilitation for specific patient cohorts to gain commitment from all those involved of how to embed Prehab within their pathways.
- Monthly meetings with a GM Active group (the group leading the physical activity programme in GM) commenced September 2018 with the specification of service provision they will provide for patients referred into the programme being finalised. This will vary according to tumour group.
- The first AHP Advisory Board meeting took place in Nov 2018 with Dietetic, OT and Physiotherapy representatives from across GM.
- They are key members of the workforce involved in the screening for the Prehab programme and delivery of more specialist Prehab interventions for the highest risk patients within hospital settings.
- The programme are collaborating with Health Innovations Manchester and building on existing work completed at the Christie and in ERAS+ to source a digital platform to support the programme or outcome measurement/data collection. Exploratory discussions have

been completed with several digital companies and expressions of interest will be invited over the next month for procurement with an outcomes based specification.

- The project team have begun the completion of patient engagement with an initial focus group held at The Christie at the beginning of November. Further focus groups will be held with patients in North Manchester and patients from ethnic minorities. IN addition, work is underway with the user involvement (U.I). Team to ensure patient representation at all pathway steering & implementation meetings.
- The programme will launch in ***April 2019*** and a presentation will be given to the GM Cancer board in March 2019.

Cancer Intelligence:

- Recruitment to the Lead Analyst and Data Manager are complete. The cancer intelligence team have already been providing high level reporting on 62 day performance, analysis on increased referrals across GM (reports presented to H&SCP performance and delivery board) and for data analysis, key to lung health checks.
- Performance dashboards will be completed by January 2019 (in final testing). Preliminary data is being shared across providers and CCG.

Recruitment is underway for key posts associated with all other projects including Project Managers and Clinical Leads. All projects will have these in place by **March 2019**, some much sooner.

1.3 Summary of key developments November 2018 –March 2019

Financial planning against key projects is already developed and financial regulation is controlled with agreements with The Christie as the hosting organisation for estates, HR and finance.

Against transformational funding plan (details below) spending YTD is £385k, due to the recruitment process commencing only in September 2018.

There are a number of Project Managers and Clinical Leads starting in post in the next 6 months and recruitment is underway for the remaining posts detailed within the PID's. Expenditure will increase considerably when moving into the financial year 2019-20 (fig 1):

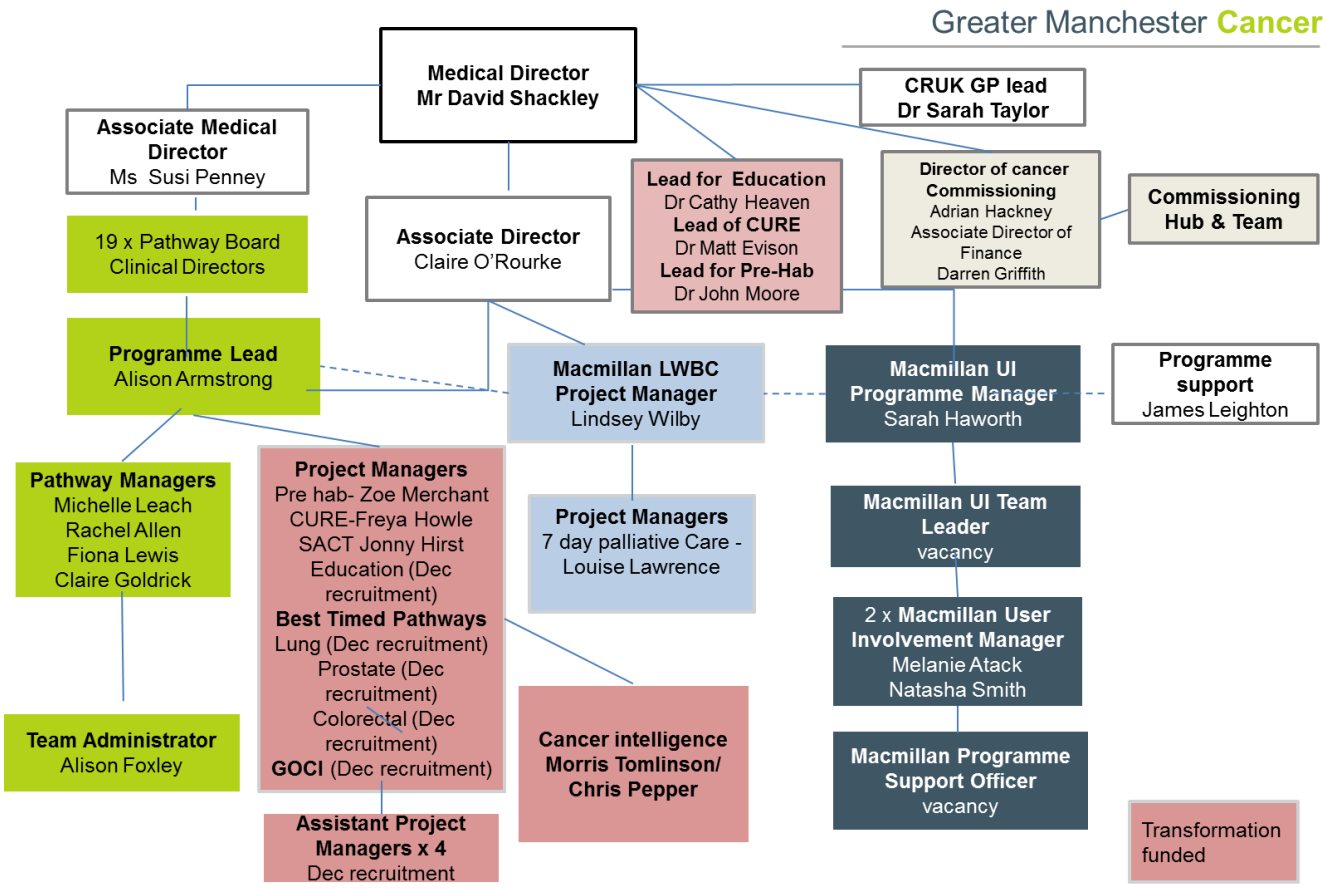
Figure 1 – GM Cancer Transformation Fund PID's

PID	Budget	Resource ask per PID	Comments	Share of balance	Total Costs
	£'m	£'m		£'m	£'m
Core Infrastructure	0.375	0.375	core funded posts continued	N\A	0.375
Accelerated Pathways - lung	3.750	1.258	recruitment to post December	0.093	1.351
Accelerated Pathways - colorectal		0.989	recruitment to post December	0.073	1.062
Accelerated Pathways - prostate		0.885	recruitment to post December	0.066	0.951
ERAS	1.688	1.667	lead posts recruited	0.124	1.791
CURE	1.875	1.866	lead posts recruited	0.138	2.004
Education	0.625	0.610	recruitment to post December	0.045	0.655

CAN / GoCI	0.563	0.564	recruitment to post December	0.042	0.606
Cancer Intelligence	0.375	0.387	lead posts recruited	0.029	0.416
Stratified follow-up	0.750	0.734	recruitment to posts December	0.054	0.789
TOTAL	**10.000**	**9.335**		**0.664**	**10.00**

The GM Cancer core team and project management support is detailed below, reflecting both the current establishment (as at Nov. 2018) and additional posts required to support the transformational projects (fig 2.)

Figure 2 – GM Cancer establishment (new post have now been recruited to):



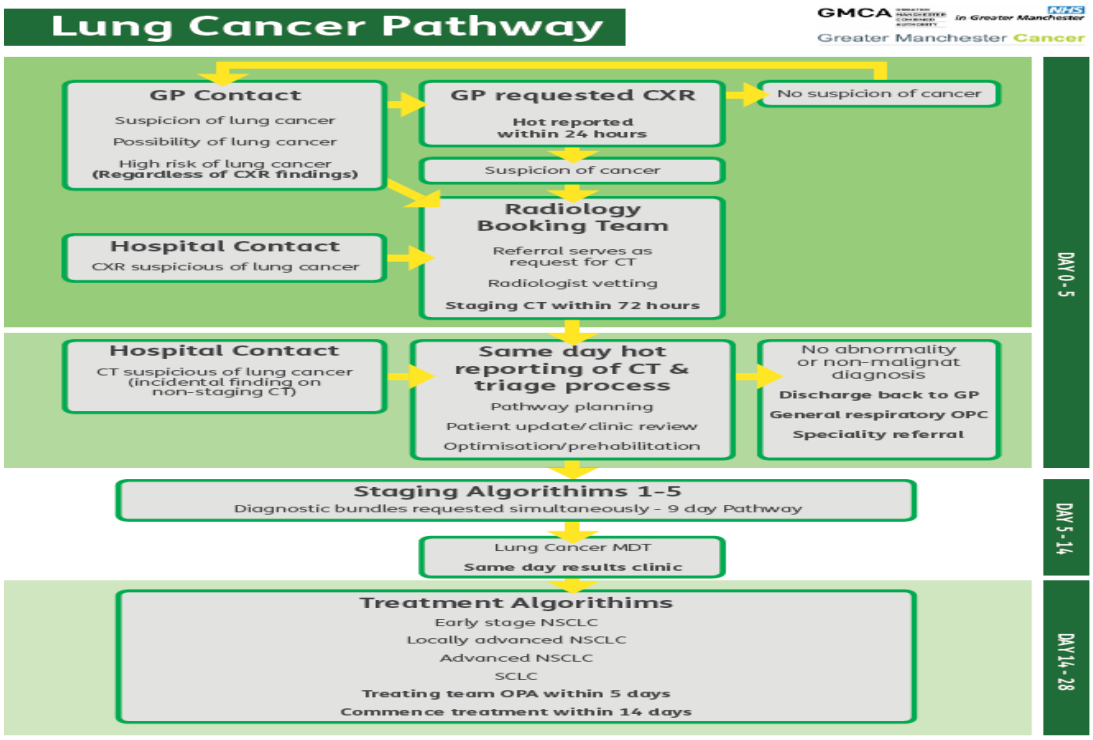
1.4 Best Timed Pathways

GM Cancer has led the development of the optimal best timed pathways as part of the vanguard programme of work and has led on the development of new GM optimal pathways in lung, prostate and colorectal cancer. The first pathway to be rolled out in **March 2019** is lung cancer, with ambitious targets accelerated beyond the national plan.

The delivery of this best timed pathway is estimated to save 100 lives per year and approximately 20% improved survival at three years from 50% to 70% in 500 patients having surgical (resection).

It is estimated that 210 more operations are required if the GM surgical resection rate increases to the level of the best performing trust (from 17% to 25%) and 1 year survival will be improved as a result. The optimal lung pathway is detailed below(fig 3)

Figure 3 – Optimal lung pathway



Following a programme of scoping work, the best timed pathways in prostate and colorectal will commence in April and May 2019 respectively.

1.5 Summary

GM Cancer is responsible for the delivery of the GM programme of work aligned with the ambitions set out in 'Taking Charge' and detailed within the GM cancer plan. Since agreement of transformation funding in September 2018, this programme of work has progressed at pace, fundamental to delivery is being the current, significant recruitment drive to both clinical and project management posts.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Paper number

3

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	18th January 2018	
Title of paper:	GM Cancer Workshop Outcomes	
Purpose of the paper:	To inform the GM Cancer Board regarding the agreed actions and outcomes from the workshop held on 16 November at Churchgate House.	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	✓	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes	The workshop included a key focus on the implementation of the GM Cancer Plan, standardisation and reduction in variation across GM.	
Improved patient experience	Improving outcomes and access and reducing variation are two key factors in patient experience.	
Reducing inequality	Workshop outcomes support an increased focus on reductions in inequality.	
Minimising variation	As improved outcomes above.	
Operational / financial efficiency	The systematic implementation, spread and sustainability of priority actions to improve outcomes, performance and deliver efficiencies through prevention and earlier stage diagnosis was a key component in workshop discussion and outcomes.	
Author of paper and contact details	**Name:** Rob Bellingham **Title:** Interim Managing Director, GM Health and Care Commissioning **Email:** robbellingham@nhs.net	

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Date: **18th January 2019**

Title: **GM Cancer 16 November Workshop Outcomes**

From: **Rob Bellingham, Interim MD, GM Health and Care Commissioning**

1. Purpose of paper

This paper sets out the outcomes and agreed actions resulting from the GM Cancer Workshop held on 16 November 2018.

2. Agreed Actions

At the conclusion of the event, a six point action plan was described and supported by those present. This plan is now being presented to the full Cancer Board for consideration and subject to review, adoption.

All of the actions have proposed leads identified but it is emphasised here that each element of the work will require broad engagement from a wide range of colleagues, not just those named. Similarly, the proposed leads are likely to wish to nominate members of their teams to support the day to day delivery of the work.

The proposed actions are described below:

i) Conduct a rapid 2-year review of the GM Cancer Plan

The GM Cancer Plan was published and agreed in February 2017, which means it is approaching its second birthday. It is therefore timely to conduct a review of progress to date which will review progress against the six priority themes and the wider aims set out in the plan to:

- Assess what has been delivered to date
- What is still to be done, confirming that the objective set out in 2017 is still relevant
- Identify any new requirements/ opportunities that have emerged since the plan was published
- Assess the impact of the NHS 10 year plan, to be published in December 2018

Suggested leads – Dave Shackley/ Richard Preece/ Roger Spencer/ Adrian Hackney

ii) **Review of cancer related NICE Guidance**

- Linked to the rapid review of the GM Cancer Plan, review the adoption and implementation of NICE Guidance relating to Greater Manchester cancer services

Suggested leads – Dave Shackley/ Richard Preece/ Roger Spencer/ Adrian Hackney

iii) **Developing our Commissioning System**

A key element of the workshop, with a series of action areas described as set out below:

- Ensuring that cancer commissioning forms part of GM work to define the future of our commissioning system
- Considering the linkages between the GM Cancer Board and the Joint Commissioning Board, recognising the opportunities that these two GM level groups working together can deliver
- Work to deliver a consistent and concerted approach between localities and the GM commissioning team, to maximise capacity and to promote effective working across commissioners and with providers. Specifically in this regard
    - Cancer Commissioning Managers meeting to move to monthly meetings, (rather than bi-monthly as at present), with Rob Bellingham to chair these meetings for the next six months
    - Cancer Commissioning Managers meeting to firm up lines of reporting/ accountability to Directors of Commissioning and Chief Finance Officers
    - A bi-monthly senior level sub-group of the GM Cancer Board, including service user membership, to review cancer commissioning issues including progress on local implementation of the GM Cancer Plan

Suggested lead – Rob Bellingham

iv) **Agreeing a system level set of outcome measures for delivery in 2019/20**

The workshop explored the concept of developing GM "Planning Guidance" for cancer services and after discussion and consideration, arrived at the concept of describing a series of measures which would be co—produced at the GM Cancer level, (i.e. providers, commissioners, academic partners, service users) and overseen by the GM Cancer Board.

- Take best practice pathways for lung, colorectal and prostate cancer through the Joint Commissioning Board governance for system-wide sign up and implementation, as initial phase of guidance
    - These three pathways are already in national guidance, they have been identified as phase 1 priorities for GM transformation funding and they support the delivery of the 62-day cancer standard

Suggested lead – Dave Shackley/ Adrian Hackney

v) **Role and Function of the GM Cancer Board**

In the light of the proposed actions described above, it will be timely to review the operation of the Cancer Board itself. Such a review is likely to encompass the following points:

- Form, function and remit of the Board
- Relationship with the JCB, (see also ii above)
- Role of the Board in overseeing delivery of the plan and outcome measures, (see also i and iii above)

Suggested leads – Richard Preece/ Roger Spencer

vi) **Resourcing**

As advocates for the development of our GM Cancer system, delegates at the workshop felt that this element was critical. The view taken at the workshop was a broad one, with the following elements felt to be in scope:

- Workforce
- Opportunities for redesign
- Investment requirements (including ensuring "fair shares" of national funding that does not sit within our GM Transformation Fund)
- Review/ evaluation – identifying what works well

Suggested leads – Richard Preece/ Dave Shackley/ Roger Spencer/ Rob Bellingham

vii) **Partnerships with Industry/ Pharma**

This issue was raised across several aspects of the workshop discussions. It is felt that this is already the subject of considerable work via elements led by Professor Rob Bristow and his team and our linkages to Health Innovation Manchester. We are not proposing any additional action to that which is already in place but are including this element here for completeness and to ensure Cancer Board members continue to be sighted on this element of the programme.

3. Recommendations

The GM Cancer Board is asked to receive this document with a view to:

- *Approving the content of the suggested action plan*
- *Approving the nominated lead arrangements*
- *Requiring that a timed delivery plan is now produced, setting out the expected timelines and proposed engagement arrangements*

Contact details:

Rob Bellingham
Interim Managing Director – GM Health and Care Commissioning
Churchgate House, Manchester
Tel: 0161 778 7101
Email: robbellingham@nhs.net

Appendix 1

Workshop Attendees

No	Name	Organisation
1.	Rob Bellingham	GM Health and Care Commissioning
2.	Andrew Bibby	North of England Specialised Commissioning Team (North West Hub)
3.	Liz Calder	Northern Care Alliance NHS Group
4.	Ian Clayton	Service User Rep
5.	Mark Chidgey	NHS Stockport CCG
6.	Bethany Darbyshire	Connected Consultants Ltd
7.	Caroline Davidson	Manchester University Hospital Foundation Trust
8.	Jane Eddleston	Manchester University Hospital Foundation Trust
9.	Andy Ennis	Bolton NHS Foundation Trust
10.	Siobhan Farmer	GM Health and Care Commissioning
11.	Nabila Farooq	Service User Rep
12.	Joanne Fitzpatrick	Christie Hospital NHS Foundation Trust
13.	Darren Griffiths	GM Health and Care Commissioning
14.	Adrian Hackney	GM Health and Care Commissioning
15.	Chris Harrison	Christie Hospital NHS Foundation Trust
16.	Coral Higgins	GM Health and Care Commissioning
17.	Matthias Hohmann	NHS Oldham CCG
18.	Fiona Noden	Christie Hospital NHS Foundation Trust
19.	Richard Preece	GM Health and Social Care Partnership
20.	Jane Pilkington	GM Health and Social Care Partnership
21.	Jennifer Riley	Bolton CCG
22.	Louise Roberts	NHS Tameside & Glossop CCG
23.	David Shackley	GM Cancer
24.	Saeed Shakibai	Service User Rep
25.	Jack Sharp	Northern Care Alliance NHS Group
26.	Louise Sinnott	GM Health and Care Commissioning
27.	Roger Spencer	Christie Hospital NHS Foundation Trust
28.	Matthew Swanborough	Manchester University Hospital NHS Foundation Trust
29.	Sue Sykes	GM Health and Care Commissioning
30.	Dr Sarah Taylor	Manchester Health and Care Commissioning
31.	Mike Thorpe	Service User Rep
32.	Dr Tracey Vell	GM Health and Social Care Partnership

Paper number

4

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	18th January 2019	
Title of paper:	Palliative and End of Life Care Commitments and Framework.	
Purpose of the paper:	• Update on the draft proposed palliative and end of life care commitments, and consultation process. • Progress with the newly formed GMH&SC Partnership Palliative and End of Life Care Programme Board • Update on progress to date of the Supportive Care Management group (SCMG) which is a sub-group of the joint partnership group with the SCMG focusing on specific cancer palliative care delivery.	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	✓	***Discussion***
	✓	***For information***
Impact	The GM commitments will set out a number of objectives and outline the outcomes that the people in Greater Manchester should expect. The Palliative and End of Life Care Programme Board workshop held in September, concluded with Elaine Inglesby-Burke, SRO/ Chair, reflecting back to us the importance of this work programme. • *This is about empowering communities'* • *'This is our Stakeholder group of champions who will meet bi- monthly/ quarterly to touch and steer'* • *'A once in a generation opportunity to standardise and scale'* • *Review each GM locality approach and take the best of the best and in doing so, reduce the variation'.*	

Improved patient outcomes	What an individual with palliative care needs should expect across Greater Manchester.
Improved patient experience	To live well during the last year of life with dignity, in the place of their choice, regardless of disease, setting, age and circumstance.
Reducing inequality	What an individual should expect to live well during the last year of life with dignity, in the place of their choice, regardless of disease, setting, age and circumstance.
Minimising variation	The Framework will contain 12 individual focused commitments and 4 system enabling commitments.
Operational / financial efficiency	The framework and commitments will enable a standardised approach to palliative and end of life care across Greater Manchester with a system wide approach/ownership, metrics and measurement enabling joint commissioning discussions.
Author of paper and contact details	**Name(s):** Dr Dave Waterman, Clinical Lead, Greater Manchester & Eastern Cheshire SCN Consultant in Palliative Medicine, Stockport NHS Foundation Trust Anne-Marie Raftery, Lead Nurse Palliative Care, The Christie & Pathway Director, Palliative Care, Greater Manchester Cancer **Email:** dwaterman@nhs.net; Annemarie.raftery@christie.nhs.uk

Greater Manchester Cancer Board

Date: 18th January 2019

Title: Palliative and End of Life Care Commitments and Framework.

From: Dr Dave Waterman & Anne-Marie Raftery

Purpose of paper

- Update on the draft proposed palliative and end of life care commitments and consultation process.
- Progress with the newly formed GMH&SC Partnership Palliative and End of Life Care Programme Board.
- Update on progress to date of the Supportive Care Management group (SCMG) which is a sub-group of the joint partnership group with the SCMG focusing on specific cancer palliative care delivery.

Recommendations

GM Cancer Board members to encourage participation in the palliative and end of life care commitments consultation process.

Contacts

Dr Dave Waterman Clinical Lead, Greater Manchester & Eastern Cheshire SCN Consultant in Palliative Medicine, Stockport NHS Foundation Trust dwaterman@nhs.net

Anne-Marie Raftery, Lead Nurse Palliative Care, The Christie & Pathway Director, Palliative Care, Greater Manchester Cancer Annemarie.raftery@christie.nhs.uk

Paper number 5

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	Friday 18th January 2019	
Title of paper:	GM ACE Wave 2 Pilot Project: The development of Multidisciplinary Diagnostic Centres (MDC's) to improve the outcomes of patients with vague symptoms	
Purpose of the paper:	The paper is intended to inform the Greater Manchester Cancer Board on progress to date with the piloting of a Multidisciplinary Diagnostic Clinic approach for patients presenting with non- specific but concerning (vague) symptoms.	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	✓	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes	This cohort of patients is frequently referred on more than one cancer pathway and experience significant delays before a diagnosis is made. The MDC approach has demonstrated that the median wait from referral to diagnosis of cancer is 11 days for over 90% of patients referred to the MDC.	
Improved patient experience	Patient Feedback: 'This service was so streamlined and professional from start to finish. Having the tests and getting the results on the same day saved me weeks /months of stress and worry – thank you'	
Reducing inequality	There is not currently a pathway for this cohort of patients. The piloting of a vague symptom pathway has reduced inequality of access for this group of patients on both pilot sites.	

Minimising variation	The use of an MDC approach for patients with vague symptoms has reduced variation in access to diagnostics for patients in the pilot areas.
Operational / financial efficiency	An MDC approach in most cases reduces the number of initial diagnostics a patient presenting with vague symptoms requires.
Author of paper and contact details	Name: Sue Sykes Title: Programme Manager Email: susansykes@nhs.net Tel: 07377656403