GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Agenda

Meeting time and date: Thursday 28th November 2019 10am-12pm

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

Chairs: Carolyn Wilkins/ Roger Spencer

#	Item	Type	To	Lead	Time
1	Welcome and apologies	Verbal	-		
2	Minutes of the last meeting	Paper 1	Approve		
3	Action log and matters arising	Paper 1	Note		5’
4	Performance against the national CWT standards in GM	Paper 2	Approve	Lisa Galligan-Dawson	15’
5	Breast Cancer Service Provision in GM	Presentation	Discuss	Clare Garnsey	10’
6	Cancer In GM: an update from the Joint Commissioning Team and GM Cancer	Paper 3	Approve	Rob Bellingham	10’
7	Cancer Patient experience survey 2018 –summary paper	Paper 4	Discuss	Paula Daley	10’
8	Long Term Plan for Cancer- Updated Plan on a Page	Paper 5	Approve	Dave Shackley/Ali Jones	10’
9	Cancer Workforce review in GM	Paper 6 Presentation	Discuss	Suzanne Lilly	10’
10	Update on GM Cancer clinical leader recruitment	Paper 7	Discuss	Alison Armstrong	10’
11	Papers for information ▪ Adrenal Cancer Summit ▪ GM Cancer Comms Brief ▪ GM Cancer led TF Projects ▪ Best Practice Pathways ▪ Mike Richards Report	 Paper 8 Paper 9 Paper 10 Paper 11 Paper 12		 David Shackley Anna Perkins Alison Armstrong David Shackley Siobhan Farmer	20’
9	AOB				10’
10	Future Meeting Dates: ▪ 20th January 3-5pm ▪ 16th March 3-5pm				

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number 1

Greater Manchester **Cancer**

Greater Manchester Cancer Board
Minutes and Actions

Meeting time and date: Monday 16th September 2019, 10-12pm.

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

Members in attendance			
Name	**Role**	**Organisation/Representation**	**Attendance 2019/20**
Carolyn Wilkins	Co-Chair Chief Executive Officer	Oldham Council	2/3
Roger Spencer (RS)	Co-Chair & Chief Executive Officer	The Christie NHS Foundation Trust	3/3
Dave Shackley (DS)	Director	GM Cancer	3/3
Chris Harrison (CH)	Executive Medical Director	The Christie NHS Foundation Trust	2/3
Richard Preece (RPr)	Executive Lead for Quality	GMHSCP	3/3
Claire O'Rourke (COR)	Associate Director	GM Cancer	3/3
Jane Pilkington	Deputy Director Population Health	GMHSCP	3/3
Susi Penney (SP)	Associate Medical Director	GM Cancer	3/3
Cathy Heaven (CH)	Chair of Cancer Education	The Christie NHS Foundation Trust	3/3
Ian Clayton (IC)	User Involvement Rep PaBC	Macmillan User Involvement Programme	3/3
Nabila Farooq (NF)	User Involvement Rep PaBC	Macmillan User Involvement	1/3
Roger Proudham (RP)	Deputy Medical Director	Pennine Acute Trust	2/3
Cheryl Lenney (CL)	Executive Director of Nursing	Manchester Foundation NHS Trust	2/3
Carolyn Wilkins (CW)	Co-Chair & Chief Executive Officer	Oldham Council	2/3
Mike Clark (MC)	GP	East Cheshire NHS	2/3

		Foundation Trust	
David Wright (DW)	TYA Lead Nurse & TYA Pathway Director	Lead Cancer nurses for GM	2/3
Darren Griffiths (DG)	Associate Director of Finance	GM Cancer and Cancer Commissioning	3/3
Tanya Humphries (TH)	Head of Services (Interim) for North West of England	Macmillan Cancer Support	2/3
Barney Schofield (BS)	Director or Planning	NCIA	1/3
Siobhan Farmer (SF)	Healthcare Public Health Consultant & Screening and Immunisation Lead	GMHSCP	1/3
Sue Sykes (SS)	Senior Programme Manager	GM Joint Commissioning Team / GM Cancer	1/3
Lisa Spencer (LS)	Director of Transformation	Salford Royal NHS Foundation Trust	2/3
Rob Bellingham (RB)	Interim Managing Director GM joint commissioning team	Greater Manchester Health & Social Care Partnership	2/3
Sarah Taylor	GP Primary Care Lead	GM Cancer	3/3
Trish Cavanagh	Chief Officer	Tameside & Glossop ICFT	
John Wareing	Director of Strategy	MFT	
Emma Greenwood	Director of Policy and Public Affairs	CRUK	

Guests in attendance			
Name	**Role**	**Organisation**	
Paula Daley (PD)	Macmillan User Involvement	Macmillan, GM Cancer	
Alison Armstrong (AA)	Programme Lead	GM Cancer	
Alison Jones (AJ)	Associate Director of Commissioning	GM Cancer	
Sarah Maynard Walker (SMW)	Programme Lead	Transformation Unit	
Melissa Shaw	Macmillan GM Project Support Officer	Macmillan, GM Cancer	
Stephen Jones	Genomics Project Manager	GM Cancer	
Suzanne Lilley	Workforce Lead	GM Cancer	
Lisa Gallighan-Dawson	Programme Director	GM Cancer	
Matt Evison	Respiratory Physician	MFT	
Richard Booton	Respiratory Physician	MFT	

Apologies			
Name	**Role**	**Organisation**	**Attendance 2019/20**
Sara Hiom	Director for Early Diagnosis	CRUK	
Fiona Noden (FN)	Chief Operating Officer	The Christie NHS	2/3

		Foundation Trust	
Kath Nuttall (KN)	*Regional Manager for North*	*CRUK*	*2/2*
Caroline Davison (CD)	Deputising for Darren Banks	Manchester Foundation NHS Trust	2/3
Louise Sinnott (LS)	Head of Place-based commissioning GM	Specialised Commissioning	2/3
Adrian Hackney (AH)	Director of Commissioning	GM Joint Commissioning Team / GM Cancer	2/3
Grace Pendlebury	Student	MMU	
Tracy Vell (TV)	Lead for Primary Care & Clinical Director	GMHSCP Health Innovation Manchester	

1. Welcome and Apologies	
Discussion summary	CW extended a welcome to all. Members of the board and guests. Apologies were noted
Actions and responsibility	No further actions.

2. Minutes of the last meeting	
Discussion summary	Minutes of the last board meeting were discussed and agreed by members as a true record.
Actions and responsibility	No further actions.

3. Action log and matters arising	
Discussion summary	The action log was briefly discussed by members of the meeting..
Actions and responsibility	No further actions.

4. Terms of Reference	
Discussion summary	A revised draft of the ToR was presented by DS to board members. DS provided reassurance that comments from the last meeting were considered and a summary based on the previous version had been developed. DS advised that due to conflicting tensions regarding voting, this element had now been removed. DS explained changes made to workforce, oversight of funding, and edited membership. AH had made changes to the governance diagram as promised in the last meeting. DS also explained that the aim will be to circulate board papers a couple of weeks in advance of the meetings in future. NC advised that there is a fleeting reference in regards to Eastern Cheshire, however nothing narrative in the membership section. TC suggested clarity regarding the workforce was required. COR assured the board that GM Cancer has now appointed a workforce lead (SL) to address this element of reporting. JW asked COR how children are being represented on the board. COR assured JW that there is a GM Cancer Clinical Lead in place to oversee, DS advised that he has spent time with the Children's Cancer Lead and appreciates that children's cancer services are completely different to adults and consideration regarding

	whether the pathway board is sufficient enough should be taken in to account. CW supported DS by explaining that it does reference 'people' so perhaps may need to be reviewed to provide clarity between adult and children. DS asked that board members reflect on any further issues and send comments by next week at which point the ToR would be finalised.
Actions and responsibility	To review ToR Send any additional comments to DS by 27.09.19

5. Long term plan response	
Discussion summary	DS reported on key points of the long term summary plan. DS advised that the work carried out aims to describe an implementation plan for cancer. GM has agreed to submit this plan to both the partnership and the national team within the next 6 weeks. DS explained the draft for this plan will be sent today. DS reported that the long term plan suggests that there is going to be significant improvement in early diagnosis and the number of people surviving cancer. The long term plan aims to provide more personalised care and an improvement to cancer waiting times. DS also advised that NHS England have an additional request to submit the progress of work and the impact this work has. Board members were presented with the plan-on-a-page document demonstrating the priorities that GM feels are the key programmes that are most suitable to the long term plan. DS asked the board members if there were any comments anyone would like to make. JP had concerns regarding the CURE reference on the plan and suggested that this would need to be more inclusive of the broader priorities of the programme. COR assured JP that this is only a summary of the key priorities, therefore, not all detail can be included in this one document. DS supported COR that there is much more detail from the programmes, however this document only focuses on the key points. CW asked DS if there is a separate plan for children. DS reported that this plan covers both adults and children. COR explained that again there is much more detail on this in the long term plan delivery document. RB asked regarding costs to gain an understanding of where the money is coming from and whether this could be added to the document. Also to be better informed of if we can't carry out those activities what will be the impact of this. COR reassured RB that details of this is the in the long term plan delivery document and will be happy to share with the board so they are able to examine the details. RS advised board members that some acceptance needs to be made on this plan, as well as the national plan and that there are a number of unknown factors. RP reported that if there is no money then workforce would be at risk. RP said there is a need to decide on the priorities, what will be reduced, stopped or continue, and that obesity should be specifically cited as an area for targeted work DS advised that the lifestyle area is a very complex issue potentially outside the immediate remit of the plan as there are, for example, many other factors such as air pollution, activity, exercise, diet alongside smoking and other factors which are best addressed through the population health domain, with cancer showing its individual contribution perhaps. RP agreed comfortable for the draft to be sent today. CW asked to send any comments to DS by next week. Board members approved the plan on a page discussed today at the Board

Actions and responsibility	COR to circulate the detailed long term plan to board members Any additional comments to be sent to DS by 27.09.19

6. Rapid Diagnostic Centre's	
Discussion summary	SS presented the visions of the RDCs for 19/20 and advised that the vision for the next 5 years will be published in October this year. SS showed board members the implementation specification and following objectives for the RDC. SS advised that the NCA and MFT are the first organisations to be leading on this programme. SS emphasised some challenges regarding funding and these are currently ongoing. SS explained that the focus for Oct-Nov will be to engage with pathway boards and review referral forms. GM are dependent on securing funding and until approval has been set then we are unable to put posts out to advert. SS advised that all CCGs have been cited on the development plan; however meetings with individual CCGs are still underway. SS reported that the two existing organisations that have carried out these pilots will inform other organisations on how it needs to be for the rest of GM. ST presented board members with issues that need to be addressed. ST advised that in addition to vague symptoms, MFT will look at lower GI, whilst NCA will look at upper GI. The aim of this will mean that all patients will be referred via this route; however this will be a huge change for GPs, which therefore means a need for GP education. ST advised that as it stands, GPs will only refer vague symptoms and that the triage in Primary Care requires education to ensure that the patient goes onto the correct pathway. ST also reported that a huge amount of work needs to be carried out regarding workforce to understand who the best people for these centres are. RP asked SS and ST why there are concerns around funding with the view that NHS England are not accountable to for signing these plans. ST advised RP that there they are still waiting for confirmation, which has created these concerns. SS advised RP that other alliances have received funding confirmation already. RP suggested that this needs escalating. RS provided assurance that confirmation is not far away. DW asked ST regarding when workforce challenges and whether the national guidance provides some of the answers regarding triage. ST informed DW that it does not currently advise but that triage is not difficult to carry out and there are lessons learned with this regard from the pilot sites. SS reported that work needs to be carried out around those patients who don't have cancer, but have a diagnosis of another chronic disease; further engagement is needed with other services to be able to create a clear plan. RS advised we want to think this of this initiative as a development for all patients in GM, not for just small group of patients; our approach should include the whole population. RS explained that NCA and MFT will be delivering this for all and that in 5 years' time there will be a significant question of how this model expands. RS advised that we should see capital allocation being connected to diagnostics and that he appreciates there is an anxiety around the funding; however we need to be confident of its implementation. RS suggested escalating this as we shouldn't be thinking about how much we can afford; more think about what we can do.
Actions and responsibility	ST/SS to escalate concerns regarding funding.

7. Lung Health Checks Programme	
	SF provided board members with an update on the lung health checks programme and the position in 3 GM localities – Manchester, Salford and Tameside & Glossop. The Manchester and Salford models are locally funded, the T&G locality are the nationally funded LHC locality for GM. SF advised that delivery of LHCs will create a demand for surgery and requires work to develop an understanding of how all 3 programmes can work together. SF reported that there is significant pressure on radiotherapy and chemotherapy provisions at the Christie which is manageable with work but the demand on surgery provisions need revising at MFT. DS supported SF by advising that this is a risk and there is a need to look at the surgery capacity at MFT and how this can be increased, as there is an additional demand of as much as 5 extra lung cancer surgeries per week across GM when these 3 CCG's were fully activated in terms of their LHC programmes. SF assured board members that that all three models are in line with the national protocol. RS asked SF if the minimum data set has is being used in all areas and not just one. SF assured RS that the minimum data set has been standardised to be used across GM. RB presented board members with a summary of the aims for lung health checks which pointed out that the key aims are improving patient experience and avoidable deaths. RB advised that the proposal suggests that it should be a single provider; however the aims are to have tight working relationship with all CCGs which is equitable. RB assured board members that hard to reach communities needs to be taken into consideration. NC advised RB that it was good to see modelling designed for East Cheshire. NC questioned how the model will address rural areas such as East Cheshire. RB assured NC that if we know the population of the area then work capturing that population isn't difficult. BS asked RB what do we know about the people who don't take up the screening and what can be done about that. RB advised that we have to make the assumption that these patients have made an informed judgement that this check is not for them, however, it is understood that an educational piece will be required to increase uptake/ awareness further. RB also advised that social deprivation is a factor as to why people may not have a scan which is something to report on in the future. RS provided assurance that every patient in GM and Cheshire is catered for in this plan and we should be ambitious enough to provide access for everyone. CW asked that any business case relating to the delivery of the Lung Health Checks programme and subsequent treatment pathways is co-produced from the outset with commissioners. TC outlined the current position in Tameside & Glossop in relation to LHC delivery and the pressure from NHSE (as this is a nationally funded pilot) to commence the checks in 2019-20. The timescale outlined for the MFT proposals and business case development is unlikely to address the pressing demands on the T&G locality.
Actions and responsibility	No further actions.

12. Papers for information	
	CRUK report – no comments GM cancer communication brief – no comments GM cancer led TF projects – no comments GM cancer conference agenda – CH advised board members that there will be an upcoming email invitation from 'eventbrite' for the conference and advised members to book tickets Screening update – no comments User involvement – NF advised board members that Macmillan will not be funding UI as of April 19. COR assured NF that the core user involvement team within GM Cancer will be supported and work is currently underway on UI going forward.
Actions and responsibility	No further actions

13. AOB	
	Reconfiguration of breast services - RS reassured members that there is an expectation that a decision will definitely be made about reconfiguration by the Joint Commissioning Board. RS asked board members how they would want to be involved in the reconfiguration of breast services. CL raised the question of where this would sit in terms of the board. RS agreed with CL that this would not be to generate more activity but that in our capabilities as GM Cancer board, are able to look at providers and have those connections to provide assurance. The GM Cancer board ToR make mention of 'holding to account' so this sits within the remit of the board. CW agreed that the system requires an overview. CL agreed to send out an update to board members.
Actions and responsibility	Breast reconfiguration update to be circulated by CL

14. Future Meeting Dates	
Discussion summary	CW thanked the board members and guests for attending. The next meeting is scheduled for: Thursday 28th November 2019 at 10am
Actions and responsibility	No further actions.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number

2

Greater Manchester **Cancer**

Name of Meeting:	Greater Manchester Cancer Board	
Date of Meeting:	28th November 2019	
Title of paper:	Performance against the National Cancer Waiting Times standards	
Purpose of the paper:	To provide the GM Cancer Board with a detailed overview of current performance against the national Cancer Waiting Times standards, and the proposed actions to deliver improvement.	
Reason for Paper: *Please tick appropriate box*	☐	*Decision*
	✓	*Discussion*
	☐	*For information*
Impact	*Please state how the paper impacts on:*	
Improved patient experience and outcomes	The primary aim is to improve patient experience and outcomes by excluding, or diagnosing and treating cancer in a timely manner in line with the national Cancer Waiting Times standards. Through improved transparency and the adoption of best practice the ambition is to far exceed the minimum national standards, and simultaneously reduce variation by provider and CCG.	
Reducing inequality		
Minimising variation		
Operational / financial efficiency	Making improvements in cancer waiting times performance will support the delivery of the operational efficiencies described in the GM Cancer Plan.	
Author of paper and contact details	Name: Lisa Galligan-Dawson Title: Programme Director for Performance, Greater Manchester Cancer Email: lisa.galligandawson@christie.nhs.uk	

Greater Manchester Cancer
Greater Manchester Cancer Board

Date: 28th November 2019

Title: Performance against the National Cancer Waiting Times standards

From: Lisa Galligan-Dawson, Programme Director for Performance, Greater Manchester Cancer

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1. Background and Context

Historically, the Greater Manchester & Cheshire region (GM&C) have performed well against all the national cancer waiting times standards. The 62 day referral to treatment (RTT) standard is the most prominent of all of the national cancer targets, and is seen as a key quality measure for patients. This standard dictates that a minimum of 85% of patients must receive first definitive treatment within 62 days from a GP referral on a suspected cancer pathway. It is widely recognised that some patients will chose to be treated after 62 days. This is built in to the tolerance.

Performance against the pure 62 day standard remained above the national standard until Q4 17/18, against a deteriorating picture nationally. The overall England average performance has failed since Q4 13/14. Although the region has failed consistently since Q4 17/18 it should be noted that a number of providers and CCG have individually continued to deliver the standards.

This paper brings together a range of data from across the system, to provide the Cancer Board with not only the current performance, but the data which forms an essential insight in to the challenges that GM&C will face in the coming months. In addition, a high level action plan is included with the aim of improving the position.

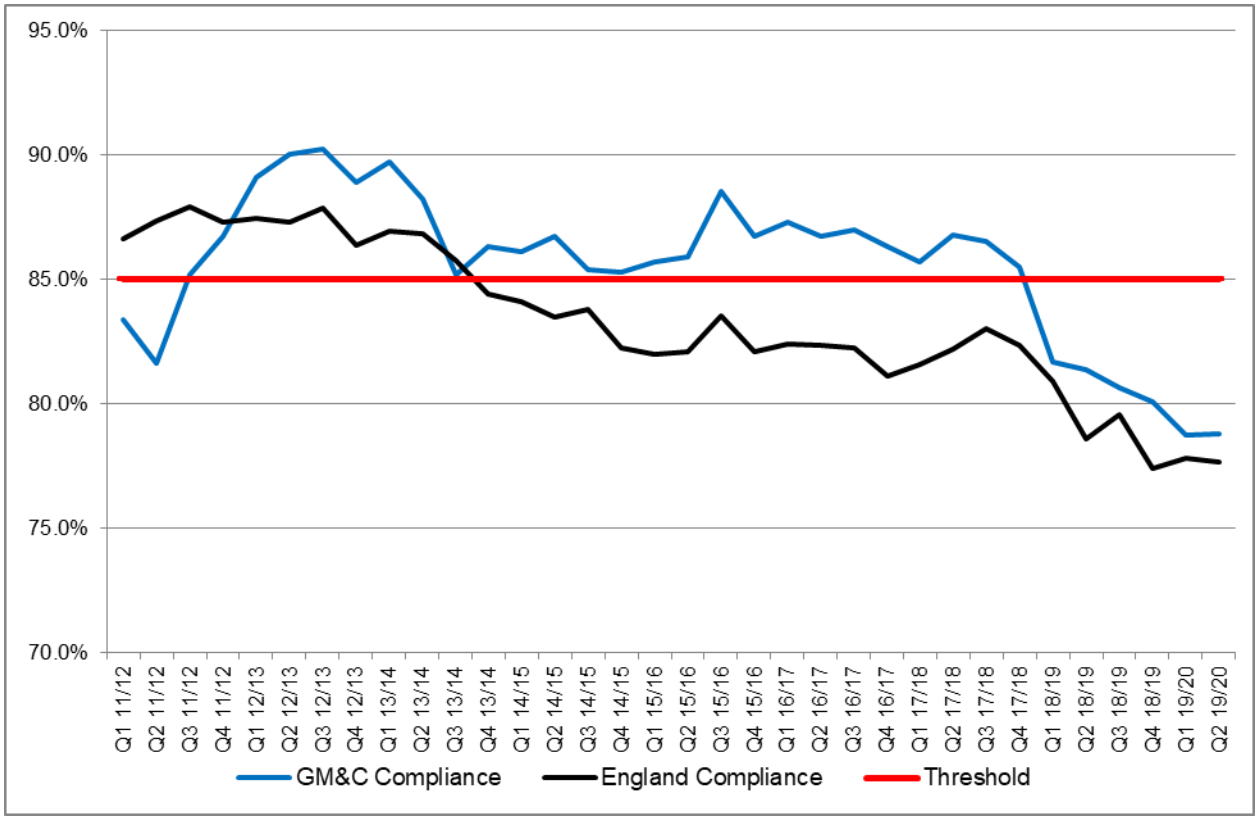
2. The Key National Standards and Current Performance

<u>62 day standard</u>

Performance for GM&C has shown steady decline and based on Q2 data the current performance falls 6.2% lower than the minimum expected standard at 78.8%. 5 providers independently delivered the standard and 2 CCGs.

The performance for the pure 62 day Referral to Treatment standard (RTT) can be visualised against the NHS England performance and the national standard overleaf:

62 Day RTT Cancer Performance Summary



To deliver the minimum standard, the region would need to convert around 150 breaches per quarter to compliances (treatment delivered in time). In terms of the current position, it is essential to quantify the cohorts of patients already in the system. Guidance dictates that all patients should be treated in order of clinical priority followed by chronological order. Therefore to deliver a reduction in breaches, backlogs of patients must be quantified and addressed.

In addition to overall deterioration, the variation by Provider and CCG has increased. In Q2 the variation between the best and poorest performing providers was 26% (Bolton and Pennine), and the variation by CCG was 28% (Tameside and Oldham) The number of patients breaching 104 days has also increased from 89.5 in Q1 to 107.5 In Q2, which is around a 20% increase indicating that more patients are waiting longer for treatment overall.

The variation of performance by tumour site is also significant. The lowest performing tumour site in Q2 was Gynaecology at 55.34%.

Screening and Consultant Upgrades

A 62 day standard is also in place for consultant upgrades (rather than GP referred patients) and screening patients; although these are measured separately from the 'pure' 62 day standard. Both of these targets are currently under the expected standard (85% and 90% respectively).

Other National Standards

A number of other standards exist. The measures detailed below correlate with the 62 day standards.

The 14 day standard (time to first attendance) sits within the pure 62 day RTT standard, and the 31 day standard from decision to treat (DTT) to treatment is designed to be incorporated within the 62 day standard. In reality, this is a separate measure and is not an indicator of good performance when viewed in isolation as the time taken to make the DTT is varied. Failure of a 31DTT standard in a provider is a clear indication of treatment capacity issues.

Performance against the 31 day DTT standard has generally been better than the 62 day performance historically. Q2 marginally passed the 96% standard at 96.7%, but the last month of the quarter (September) failed to deliver the standard.

There is a direct correlation between the 2ww standard and 62 day performance. The position has deteriorated with Q2 at 87.04% against the target of 93% of patients seen within 14 days. There is significant variation between providers of over 27% (Mid Cheshire best performing at 97% and Salford being the poorest performer at 69%). CCGs had variation of over 21%. For context this equates to just over 4000 patients waiting longer than 14 days for an appointment / straight to test diagnostic in Q2. Over 900 of these patients waited 22 days or longer. Given the complexity of pathways, it is unlikely that patients with a positive diagnosis, who have been seen this late for their first attendance, could be treated in time. This cohort of patients is likely to still be in our system currently.

3. Untreated Patients post 62 Days

Although there is no national measure for this, the number of patients who have already beached 62 days and remain on provider PTLs untreated / undiagnosed must be quantified. Regardless of the improvements made within the front end of the pathways, treating patients in chronological order dictates that unless the existing 'backlog' is cleared, these interventions are unlikely to result in improved performance.

As of 29 October, there were over 700 patients within the current system who have already breached 62 days. For context, to deliver the 85% standard the region would need to have less than 330 breaches per quarter.

The highest proportion of the current 62 day breaches on provider PTLs are with Pennine Acute Trust and Manchester Foundation Trust. Several Trusts report that a number of patients within this cohort are expected to be removed from the suspected cancer pathway, although they have already breached 62 days before non-cancer is recorded. Whilst quantifying these volumes, the number of patients breaching in the previous 7 days was recorded as 130.

In addition to the pure 62 day breaches, there are at least 150 patients beyond 62 days on the current upgrade and screening PTLs.

Due to individual cancer data systems in each provider, it is impossible to correlate the number of existing 62 day breaches automatically, as of 29 October the breakdown of patients already beyond 62 days by specialty is:

Specialty summary of patient volumes on live provider PTLs past 62 days
(As at 29.10.19)

Specialty	Patient Numbers
Breast	16
Lower GI	239
Gynaecology	64
Haematology	30
Head and Neck	37
Lung	60
Paediatrics	1
Upper GI	106
Urology	113
Skin	88
Sarcoma	5
Cup/Other	5

*manual data collection

The backlog must be significantly reduced before performance against the 62 day standard will improve.

4. Horizon Scanning

By the nature of the national reporting mechanisms, performance is always reported retrospectively (I.e. September and Q2 performance was only released on 14 November). There is therefore a significant lag in the visibility of performance.

Within GM&C provider cancer management teams produce predicted performance against the 62 day standard for the previous month. There is no predictive performance mechanism in place for any other standard.

At present the provisional October position reflects a further deterioration in performance of approximately 5% compared to the Q2 position. At present it is forecasted that there are over 200 breaches alone in October.

Given the known challenges, it is also essential to quantify the PTLs to understand the volumes of patients which may be at risk of breaching the standard in the coming months. As of 29 October, there were over 1600 patients beyond 38 days on their 62 day pathway without a treatment plan in place. Whilst providers have estimated that approximately 60% of these will be removed as non cancer this still equates to around 650 patients who may have cancer. It is reasonable to assume that a patient with cancer without a plan to treat in time by day 38 is at high risk of breaching the standard.

5. Causes of Deterioration.

There are a wide range of issues which have collectively contributed to the deterioration of performance.

These include:

- Conflicting priorities – urgent care, 18 week RTT PTL size, DM01, 52 week breaches
- Advanced treatment types often need longer work up / planning. Additionally there are more patients with co-morbidities which require management
- Pathway changes – introduction of sophisticated diagnostics, treatment planning tools and items such as high risk MDTs increases the volume and complexity of steps to be completed within 62 days
- Changes to national guidance
- Patient choice
- Failure to implement previous recommendations – (System Review by Miss Penney)
- National FDG shortages leading to increased wait for PET scan (current waiting times 10.7 days on average from request to scan and from scan to report 15.3 days).
- Capacity and Demand

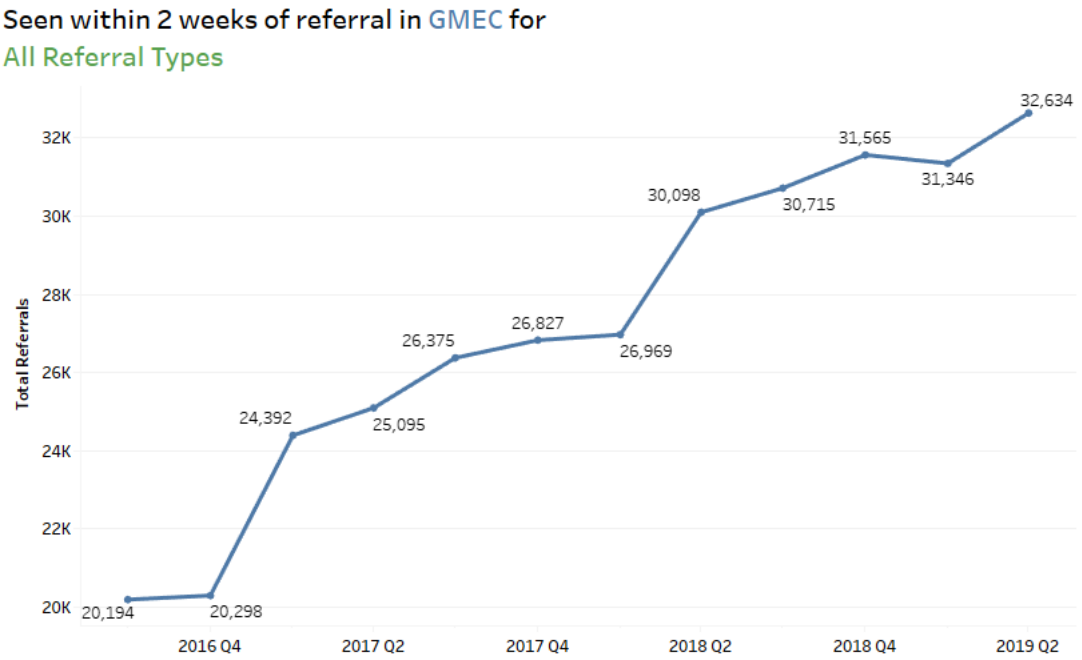
The greatest sole impact is believed to relate to capacity and demand.

<u>Demand</u>

Demand has risen year on year, but most significantly following the NICE guidance change in 2015. Patients are being actively encouraged to present with symptoms and with the lower referral thresholds; an increase in demand is inevitable.

Demand has not increased at the same rate within all specialties, and although referral rates have increased significantly, in some months individual specialties within providers have seen increases of over 40% when comparing to the previous year.

The referral increase can be visualised here:



Capacity

Capacity provision has not kept up with the growth in demand in a number of areas. There are a number of factors contributing to this. National and regional work force challenges for hard to fill posts, financial constraints, commissioning, historic capacity deficits.

Recently some providers have also encountered reductions in PAs and the inability to deliver enough additional activity through waiting list initiative (WLI) due to pension and tax changes within the medical workforce. This has compounded an already significant capacity problem.

The most significant impact is seen within diagnostic provision. This includes core diagnostics such as CT, MR, Endoscopy, CT guided biopsy and more specialist diagnostics such as PET, EBUS, EUS and treatment planning tools such as CPEX and the provision of histopathology.
There is the requirement to review the commissioning levels of diagnostics across the sector.

Despite the significant increase in demand and new recording requirements relating to the introduction of the Faster Diagnosis standard, there has not been consistent investment in the cancer performance and tracking teams proportionate to the workload increase.

6. Improving Performance

It is essential that as a system we fully understand the current and expected future performance position based on the estimations highlighted in section 3 and 4 and the associated challenges that this brings.

The position in GM&C is not dis-similar to other Alliances, as indicated by the national performance levels. However, GM&C have adopted a new, innovative approach to addressing the underperformance. A Cancer Performance Director has been employed by GM Cancer to provide dedicated resource and expertise within the system and to drive a programme of improvement work.

Locality work is essential, as is wider system working to address backlogs. Additionally though, this new role will provide a new dynamic in terms of working impartially and across a whole system, with the ability to provide micro level review work whilst uniquely having the ability to drive changes in pathways that span multiple Trusts across the GM&C footprint, and introduce system change simultaneously.

With strong performance management skills a 'marginal gains' approach will be utilised, whilst larger scale change projects are initiated. There will be a detailed review of performance management standards and processes, with a view of sharing best practice and ensuring appropriate standards are in place from a performance management perspective. A Performance and Transformation Board is being established with the first meeting scheduled for 02 December. Governance arrangements will be defined and the new Board will report formally to the GM Cancer Board. NHSE have stated that the GM Cancer alliance must lead 62 day assurance for the system, and as such quarterly Alliance reviews have been initiated. The Performance and Transformation Board minutes and actions will be shared at these meetings.

Priority support has commenced with Pennine Acute Trust, with a number of performance management changes being implemented and trialled from November. Review work has also commenced in Stockport and East Cheshire Trusts.

The actions identified as being essential to improving performance and delivering the national standards encompasses a range of work which has already commenced – introduction of Best Timed Pathways, developing Rapid Diagnostic Centres (RDCs) and workforce reviews, alongside a range of additional actions to be undertaken. The draft 'plan on a page' action plan can be found in Appendix A; once approved a full action plan will be developed to accompany this.

<u>Action Prioritisation</u>

Following induction meetings with provider Director of Operations, Lead Cancer Commissioners and the Cancer Managers Forum, the following actions have been suggested as being the key priorities:

- Provide Assurance (not reassurance) around performance management to GM Cancer Board and GMHSCP – begin developing an agreed set of standards
- Analysis of key challenges across pathways – the detail (using pathway analyser) – plan for System breach reduction following the evaluation (by full pathway, not just individual provider) – including diagnostics
- Focussed work on time to first OPA / first attendance type / booking and removal processes / diagnostic bundles by provider / by tumour site
- Locality backlog reduction plan and trajectory
- Evaluate quick wins – i.e. front end of pathway, non-admitted treatments, key pathways – costs, deliverables, funding, impact assessment
- Establish performance board and associated governance processes
- Establish a new suite of key metrics and data to create improvement tracking, which will lead to a wider recovery trajectory in due course.

7. Summary

Whilst there are significant challenges in the system, and significant work to undertake in order to eliminate and prevent further backlogs from developing, there is a strong desire to improve performance and a wide range of actions defined to make the necessary improvements.

Delivery of improvement must be founded upon transparency, engagement, shared vision and collaboration, and with the appropriate leadership free from cognitive dissidence.

8. Foot note

The quality of care, patient experience and outcomes remains the absolute priority in GM&C and people affected by cancer remain pivotal to all improvement work. However, as performance against the national waiting times standards are measured purely in percentage terms, this report is internally focussed on numbers and percentages.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number

3

Greater Manchester **Cancer**

Name of Meeting:	Greater Manchester Cancer Board	
Date of Meeting:	28th November 2019	
Title of paper:	Report to GM Joint Commissioning Board Executive – Cancer in Greater Manchester	
Purpose of the paper:	The purpose of this report is to provide The GM JCBE with a further and more detailed update on the work programme of GM Cancer and the Joint Commissioning Team, and to further develop the links between GM Cancer Board and the Joint Commissioning Board.	
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 JCBE on the delivery of improved patient outcomes in Greater Manchester – including those set out in the national Long Term Plan (LTP) for cancer.	
Improved patient experience	The paper will aim to update the JCB Executive on the steps GM Cancer will take to improve patient experience for cancer patients.	
Reducing inequality	The paper will aim to update the JCB Executive on the steps GM Cancer will take to reduce inequality by working with localities to a shared prospectus, more open use of data, and including with locality plans the delivery of the LTP for cancer.	
Minimising variation	The paper will aim to update the JCB Executive on the steps GM Cancer will take to reduce unnecessary variation including standardising many areas of practice and developing more single GM cancer services.	
Operational / financial efficiency	There is clear evidence within the report of engagement with appropriate commissioning and CCG finance teams, and information included regarding finance and cancer services.	
Author of paper and contact details	Name: Rob Bellingham / Alison Jones Title: Managing Director – GM Joint Commissioning Team / Associate Director of Commissioning – Cancer Services Email: rob.bellingham@nhs.net / alison.jones8@nhs.net	

Greater Manchester Joint Commissioning Board Executive

Date: December 2019

Subject: CANCER IN GREATER MANCHESTER: an update from the Joint Commissioning Team and Greater Manchester Cancer

Report of: Carolyn Wilkins, Chief Executive Oldham Council / Accountable Officer Oldham CCG / Co-Chair of GM Cancer Board
Roger Spencer, Chief Executive, The Christie NHS Foundation Trust / Co-Chair of GM Cancer Board

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4 **PURPOSE OF REPORT:**

The purpose of this report is to provide a further and more detailed update on the work programme of GM Cancer (the Cancer Alliance for Greater Manchester) and the Joint Commissioning Team, and to further develop the links between GM Cancer Board and the Joint Commissioning Board

KEY ISSUES TO BE DISCUSSED:

This report includes information on:

- The NHS Long Term Plan and Cancer
- GM Cancer priorities and governance
- Investment in cancer in GM
- Current challenges and key issues

5 **RECOMMENDATIONS:**

The Greater Manchester Joint Commissioning Board Executive is asked to consider and respond to the recommendations included in section 7 of this report.

6 **CONTACT OFFICERS:**

Rob Bellingham, Managing Director, Greater Manchester Joint Commissioning Team
rob.bellingham@nhs.net

CANCER IN GREATER MANCHESTER

1. Background and context

1.1. The JCB received a report in June 2019 which provided clarity on the objectives, leadership and reporting arrangements for each of the priority programmes of the GM Joint Commissioning Board, one of which is Cancer: *To deliver the objectives of the GM Cancer Plan, the National Cancer Plan, Operational Planning and Contracting Guidance and the Long Term Plan with respect to cancer services, and to do so with the involvement of the GM and Eastern Cheshire localities from design, implementation, monitoring, evaluation through to consideration for sustainability.*

1.2. A report to the JCB in February 2019 stated that: *a recent workshop identified the need to review and refresh some of the governance arrangements regarding cancer services in GM* ***including connections to chief and accountable officers and the Joint Commissioning Board****. These reforms combined with the 100-Day Commissioning Review provide opportunities for agreement on system-wide outcomes and delivery measures and how local decision making and variation at system level can be reconciled and managed*.

1.3. This report is being shared with the JCB to provide a further and more detailed update on the work programme of GM Cancer (the Cancer Alliance for Greater Manchester) and to further develop the links between GM Cancer Board and the Joint Commissioning Board.

2. Greater Manchester Cancer (Cancer Alliance)

2.1. Greater Manchester (GM) Cancer works on behalf of the cancer system in Greater Manchester and Eastern Cheshire (GM&EC) as the 'integrated cancer system' to transform cancer services and outcomes. GM Cancer is the Cancer Alliance for GM and works on behalf of NHS England and the H&SCP to deliver on the Long Term Plan for cancer over the next 5 years. More detail on GM Cancer can be seen in **Appendix 1** to this report.

3. Delivering the Long Term Plan: Cancer

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

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

3.2. The NHS Long Term Plan (LTP) Implementation Framework[1], issued in June 2019, states that '*Local systems should engage with their Cancer Alliances to set out practically how they will deliver the Long Term Plan commitments for cancer over the next five years including on early diagnosis and survival, while improving operational performance through interventions*' by:

- Improving one year survival rate
- Improving bowel, breast and cervical screening uptake
- Roll-out of FIT for symptomatic and non-symptomatic populations in line with national policy, and HPV as a primary screen in the cervical screening programme
- Improving GP referral practice
- Implementation of faster diagnosis pathways
- Improving access to high-quality treatment services, including through roll out of Radiotherapy Networks, strengthening of CYPs Cancer Networks and reform of MDT meetings
- Roll out of personalised care interventions, including stratified follow-up pathways, to improve quality of life

3.3. GM Cancer, as the Cancer Alliance for Greater Manchester and as part of the GM Health & Social Care Partnership, has led the development of the response to the Long Term Plan and is establishing a programme of work to support its delivery. A 'plan on a page' version was approved by the Cancer Board on 16th September and submitted, along with the detailed plans, to the Partnership. The 'plan on a page' is shown below and attached at **Appendix 2**.

[1] https://www.longtermplan.nhs.uk/implementation-framework/

Greater Manchester Cancer

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

LTP aims	**(1) By 2028, 75% of people will be diagnosed at an early stage (stage 1 or 2).** (GM % stage 1 and 2 [2018/19, Q1] = 53.6%) **(2) Delivery of National CWT standards**		**By 2028, 55,000 more people will survive cancer for five years or more each year.** (GM figure would be approximately 2750)	
	Prevention	**Early Diagnosis**	**Treatment**	**Personalised on-going Care**
	Appropriately skilled and resourced cancer **workforce** & sustainably funded core GM cancer alliance cancer team			
GM System Priorities	**CURE Smoking cessation programme** sustained delivery in admitted patients with expansion into mental health and non-admitting services (Linked to GM population Health programmes)	Screening (deliver in conjunction with Population Health): **Uptake** GM screening uptake improvement programme focusing on health inequalities	**Prehab4Cancer** – 100% of patients offered appropriate prehab for Cancer before all treatment modalities	**Personalised Care** Ensure all appropriate patients have holistic needs assessment, care plan & health / wellbeing information
		Effectiveness – FIT; Primary HPV screening; Targeted screening e.g. familial genetics testing (lynch etc.)	**Integration of GM services** - Delivery (i) established surgical (ISC) transformation programmes;(ii) GM-level psychology, SACT, lymphoedema, palliative care & acute oncology (iii) National service specifications	
		Lung Health checks phased sustainable roll out across all localities in GM initially through 3 localities *(Manchester, Salford, Tameside & Glossop)*	**Advanced treatments** – Ensure equitable access to latest treatments. Engage proactively in the national 'Call for innovations/ investment fund'	**Personalised Follow up** Develop personalised tools & infrastructure, with initial focus on breast, prostate and colorectal before broader roll out to all patients by 2024
		GP Education : Improve uptake of Gateway C Improving referral modules	**Research** – Improve access to trials for all patients (including shift towards early diagnosis research), investing in sample collection/ research expertise	
	HPV – Deliver HPV vaccination programme in boys	**Rapid Diagnosis Centres (RDC)** –Through at least 2 RDCs 100% of patients having access by 2024	**Genomics** - Mainstream Genomic medicine across GM into all cancer pathways.	Deploy **National Quality of Life metric.**
	Cancer Prevention Drugs - roll out in line with NICE Guidelines.	**Accelerated timed Pathways** – Adoption & further development across all disease pathways, using GATEWAY-C portal to improve awareness	**MDT** – Streamlining & standardisation with regular review of protocols, decision making and outcomes	Develop & **integrate PROMS** into digitally enabled personalised follow up tool(s) for all cancer pathways
Locality Cancer Priorities (Representing strategic commissioning & Provider Trusts)	Monitor, deliver, improve & sustain **CURE programme** (as above)	**Screening** – Develop & deliver screening uptake interventions through PCN & localities	**Prehabilitation** – Partner in development and sustainable delivery of prehabilitation	**Personalised follow up** – Develop and sustainably deliver patient-friendly, digitally enhanced personalised follow up options
		Monitor , evaluate & deliver screening enhancements & **LHC program** in each locality	**MDT** – Partner in MDT reform (see above)	
	Monitor, deliver, improve & sustain **HPV vaccination programme** (boys/ girls)	**Rapid diagnosis centres/ referral practice** - multi locality planning & delivery for the local population through PCNs (GP referrals) and localities	**Transformation** - Partner in the setup and local delivery of improving specialist care models (ISC), psychology, SACT, lymphoedema, palliative care, acute oncology & national service specifications	Coordinate 'people affected by cancer' access to suitable **health and social care support** to enable effective personalised care/ follow up
	Monitor, deliver, improve & sustain patient access to cancer prevention drugs in line with NICE defined targets	**Accelerated timed pathways** – 1) Monitor, deliver, improve & sustain & 2) Ensure sufficient local diagnostic capacity to deliver FDS	**Genomics** – Partner in the modernisation of pathology practice to integrate genomic medicine pathways into patient care in a timely manner	
System dependencies	Population Health improvements in domains associated with cancer	Comprehensive access to **cancer intelligence** (eg FDS etc) to understand inequalities & evaluate progress	Deployment of digital radiology, digital pathology and radiotherapy **clinically-networked services**	**Shared decision making** tools

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

3.5. The detailed plans submitted to the Partnership have been shared with CCG colleagues via Directors of Commissioning (and with provider Chief Operating Officers) with a request to reflect this in their locality responses and Locality Plan refresh.

3.6. Trajectories have been developed, in line with Cancer Alliance guidance and NHS LTP expectations, to show the GM position against 1 year survival and early diagnosis (stage 1 and 2). The graphics below show the expected progress towards improving 1 year survival, and early stage diagnosis.

1 Year Survival

				2016 (Baseline)		2019/20	2020/21	2021/22	2022/23	2023/24
E56000019	Greater Manchester	Rate	One-year cancer survival rate (%)	72.10%		75.10%	76.00%	76.90%	77.80%	78.70%

Proportion of Cancers Diagnosed at Stage 1 or 2

				2017 (Baseline)		2019/20	2020/21	2021/22	2022/23	2023/24
E56000019	Greater Manchester	Numerator	Numerator	6,706		7,387	7,673	8,010	8,346	8,775
		Denominator	Denominator	12,525		13,311	13,605	13,898	14,191	14,486
		Rate	%	53.54%		55.50%	56.40%	57.63%	58.81%	60.58%

3.7. GM Cancer established a Cancer Intelligence Team during the Vanguard project. This team are now transferring to the management and oversight of the GM Health & Social Care Partnership Business Intelligence Team. This will ensure the cancer data is presented to the GM system alongside other GM health & social care data and will provide the analysts with BI peer support and expertise. This will also enable the presentation of more detailed cancer intelligence at a locality and Primary Care Network level, including specialised commissioning and public health information, providing commissioners and providers with cancer data across the whole pathway.

3.8. Many elements of the Long Term Plan are national standards and 'must do' requirements for localities. GM Cancer and the Joint Commissioning Team will continue to provide support to localities, in some cases via fixed term Transformation Funding (and the associated Projects), by working with the locality Cancer Commissioning Managers and via the work of the 19 Pathway Boards (reporting to the Cancer Board). Much of the work to deliver the Long Term Plan is already underway, but there are some challenges which need to be addressed (as outlined in section 6 of this report). Continued funding for the core GM Cancer team is being addressed via discussions with Provider Federation Board and Directors of Finance (provider).

3.9. Previous reports to the Cancer Board and JCB detailed an intention to deliver a consistent and concerted approach between localities and the GM Joint Commissioning Team, to maximise capacity and to promote effective working across commissioners and with providers. The Commissioning Leadership Group has acknowledged the significant improvements that have been made with regard to locality connectivity. The Managing Director of the GM Joint Commissioning Team is leading a piece of work to review the opportunities for a potential new model for the commissioning of cancer services. Locality engagement is vital to this development.

4. Investment in Cancer in Greater Manchester

4.1. The GM Cancer Commissioning team are working closely with nominated representatives on behalf of the Chief Finance Officers (CCG) to develop the approach to the financial modelling of the GM cancer projects and delivery of the Long Term Plan**.**

4.2. The GM Cancer LTP submission did not require detailed costings to be included in the first return, however GM Cancer are working with CCG finance and commissioning representatives on the development of a model to ensure this detail is developed to support the implementation from 2020-21 onwards and to understand financial implications from a commissioner and provider perspective.

4.3. The information below shows current investment in cancer services in GM. Demand and therefore investment in cancer services has grown, and continues to do so. The delivery of the Long Term Plan priorities relating to cancer, ongoing CCG and specialised commissioning investment, and the investment of Transformation Funding as outlined below, in addition to the further analysis from a programme budgeting perspective, will enable a detailed analysis and projection of demand and spend to 2023-24.

Current investment – CCG spend

4.4. Programme Budgeting provides a framework for the presentation of NHS expenditure across programme categories covering the whole care pathway, one of which is cancer. The proposal is to take an approach with cancer commissioner which is in line with the methodology used in mental health commissioning at GM level. This will enable the system to review the totality of investment in cancer services and spend on cancer.

4.5. The CCG Deputy Chief Finance Officer representatives who are working with GM Cancer commissioners have collated Programme Budgeting information for cancer from all 10 CCGs. For the purpose of this report, the information has been summarised, but is available in detail by pathway, area of spend (primary / scheduled / unscheduled etc) and by CCG.

4.6. The information shared indicates that in 2018-19 the CCGs in Greater Manchester invested £137m in cancer services across primary (prescribing), scheduled and unscheduled care. The table below illustrates this spend set out by cancer pathway.

GM CONSOLIDATED POSITION - VALUES IN £'000	Gross Expenditure
Head or neck cancers	2,045
Upper gastrointestinal cancers	6,491
Lower gastrointestinal cancers	16,912
Lung cancers	6,400
Skin cancers	3,791
Breast cancers	22,885
Gynaecological cancers	2,504
Urological cancers	10,371
Haematological cancers	15,876
Cancers and tumours (Other)	50,506
Total GM Cancer	**137,782**

4.7. The Programme Budgeting approach also enables the application of projected growth to the 2018-19 figures. Whilst this is an approach which would need more refined work, applying net tariff inflation assumptions to the 2018-19 figures brings the total spend to £164.7m by 2023-24, which offers significant scope to review the total investment in cancer services in GM.

GM FORECAST TO 2023-24 - VALUES IN £'000	Total GM
2019-20 net tariff inflation	**144,092**
2020-21 net tariff inflation	**149,352**
2021-22 net tariff inflation	**154,698**
2022-23 net tariff inflation	**159,865**
2023-24 net tariff inflation	**164,757**

4.8. The data collated also shows a variation by CCG. More detailed work will be needed, working with commissioning teams in localities, to understand any true variation with factors such as weighted population and cancer incidence taken into account.

Current Investment – Specialised Commissioning

4.9. The NHSE North West Specialised Commissioning team lead the commissioning of specialist cancer treatments – e.g. radiotherapy, chemotherapy and specialist cancer surgery. In GM this is led by the Cancer Service Specialist for NHSE/I for the North West, and the Head of Place Based Commissioning – GM (Specialised Commissioning). The latter post sits within the GM Joint Commissioning Team infrastructure, therefore ensuring alignment with all GM programmes of work, as well as linking in with each of the localities.

4.10. NHS England is the lead commissioner for the contract with The Christie and for other Specialised Commissioning activity with providers across GM. The GM Joint Commissioning Team provides contract and commissioning support to CCGs in their associate role to these contracts.

4.11. Overall spend in Greater Manchester on cancer treatment in 2018-19 was as follows: Chemotherapy £115m, cancer surgery £57m, children's cancer £23m and radiotherapy £22m. Increased cancer treatment is creating operational and financial challenges across the health economy. Demographic growth, treatment advances, investment in GM screening programmes and workforce gaps are putting increased pressure on specialised services.

4.12. The specialised commissioning team will work with the Joint Commissioning Team and GM Cancer to profile growth assumptions in the years 2019/20 - 2023/24 and will include within this the mitigations and reductions in demand delivered via the LTP.

Current Investment – Transformation Funding (GM Cancer)

4.13. Localities will be aware that GM Cancer received £10m from the GM Transformation Fund to support a series of projects as set out below. Funding to support the delivery of these projects is available until 31/3/2021.

GM Cancer Transformation Funded Projects - spend to date and forecasts

Project	ACTUAL 2018-19 £'m A	Spend to end P5 2019-20 £'m	REVISED FORECAST 2019-20 £'m B	REVISED FORECAST 2020-21 £'m C	REVISED Total £'m A+B+C
CANCER INTELLIGENCE	0.140	0.078	0.247	0.000	0.387
CORPORATE COSTS	0.000	0.138	0.332	0.332	0.664
LUNG Best Timed Pathway (BTP)	0.010	0.035	0.343	0.905	1.258
COLORECTAL BTP	0.010	0.029	0.262	0.717	0.989
PROSTATE BTP	0.010	0.032	0.359	0.516	0.885
PREHAB4CANCER	0.036	0.281	0.708	0.424	1.167
Living With & Beyond Cancer	0.000	0.000	0.142	0.358	0.500
CURE	0.027	0.068	1.151	0.688	1.866
EDUCATION	0.022	0.057	0.307	0.281	0.610
GOALS OF CARE	0.100	0.095	0.227	0.237	0.564
STRATIFIED FOLLOW UP	0.008	0.028	0.124	0.602	0.734
CORE TEAM COSTS	0.000	0.078	0.188	0.188	0.376
	0.363	0.919	4.389	5.248	10.000

4.14. To ensure an appropriate level of governance and rigour is applied to the transaction of GM Cancer TF, GM Directors of Commissioning and Chief Finance Officers / Deputy Chief Finance Officers have supported an approach whereby the TF from GM Cancer is transacted via CCGs, using standard NHS contract documentation, service specifications and contract variations.

4.15. Some of these projects may potentially have a financial impact beyond 2020-21. The GM Cancer Commissioning Team is working with the Deputy Chief Finance Officers and Directors of Commissioning / Cancer Commissioning Managers on the detail of the evaluation and sustainability process. The intention is to ensure localities are provided with the information necessary (in the form of business cases where appropriate) for them to make an INFORMED decision with regard to the sustainability of projects currently supported with Transformation Funding.

5. GM Cancer Board and Governance

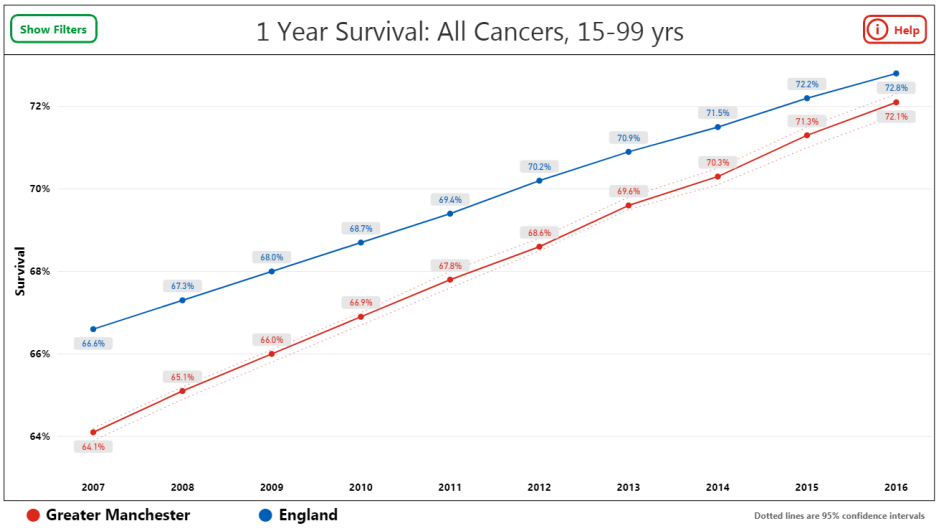
5.1. The GM Cancer Board oversees the delivery of this programme of work on behalf of the Health & Care Board. The GM Cancer Board through officers / board members reports to both the GM Joint Commissioning Board and the GM Provider Federation Board. The Joint Commissioning Board is the decision making body for commissioning elements of this programme of work, with necessary delegations in place from each CCG to facilitate this.

5.2. The Board is co-chaired by Carolyn Wilkins (Chief Executive, Oldham Council; Accountable Officer, Oldham CCG) and Roger Spencer (Chief Executive, The Christie NHS Foundation Trust) and represents all partners in the Greater Manchester cancer system. Revised Terms of Reference for the GM Cancer Board were approved at their meeting on 16th September and are attached to this report at **Appendix 3** for ratification by the JCB.

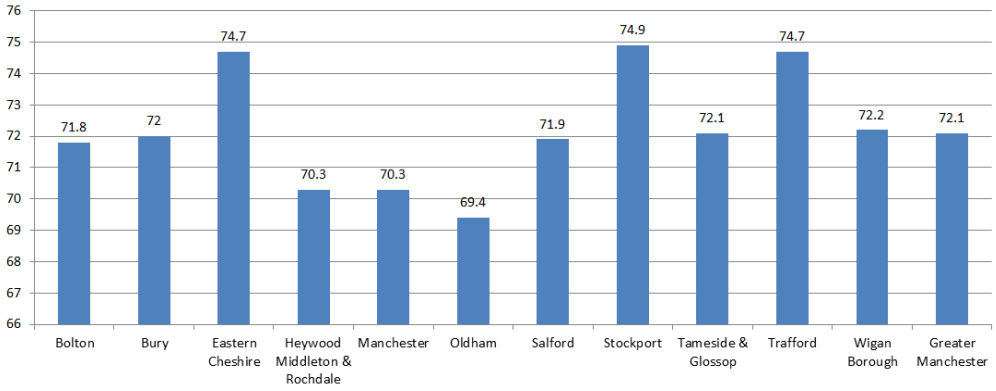
6. Current Challenges & Key Issues

6.1. 1 Year Survival in GM

6.1.1. A report was presented to GM Cancer Board in May 2019 which outlined the GM 1 year survival position. The report showed that 1 year cancer survival for Greater Manchester is 72.1%, a steady increase over time (as illustrated in the chart below). This is the latest available data, which was published on 1st April 2019. The data is for patients diagnosed in the calendar year 2016. The comparable figure in 2007 was 64.1%. It should be noted that the national data excludes children's cancer and prostate cancer, and so is of limited benefit in international benchmarking. The data is also approximately 2 years out of date, in terms of the real time outcomes experienced today.



6.1.2. The data presented on the Cancer Intelligence Service portal allows for analysis by CCG, therefore allowing for individual CCG 1 year survival comparison vs the GM data. The data below shows there are 3 CCGs who are above the GM figure (Eastern Cheshire, Stockport and Trafford) and 3 who are substantially below (HMR, Manchester and Oldham).



6.1.3. Data on 1 year survival for breast, colorectal and lung cancer also shows variation across GM and the CCGs, and was included in the report presented to the Cancer Board. This report and the data have been shared with the CCG leads in localities, with the Cancer Board request that localities undertake further analysis of this data, and use this to address areas where the position could be improved.

6.1.4. As indicated in section 3.6 of this report, the 1 year survival indicator is one for which the GM Cancer Alliance have submitted a trajectory to 2023-24 as part of the national LTP process.

6.2. **Delivery of Cancer Waiting Time Standards**

6.2.1. The delivery of the Cancer Waiting Time Standards remains a challenge across GM. GM Cancer is supporting provider trusts and CCGs in identifying and addressing and the areas where there is underperformance. GM Cancer has appointed a Programme Director – Cancer Performance who has taken up post in October 2019 to provide challenge and support to the system.

6.2.2. The GM Joint Commissioning Team are mobilising commissioner input to the developing GM approach to cancer performance, requesting expressions of interest from CCG Cancer Commissioning Managers to be involved in the GM Cancer Performance and GM Cancer Commissioning Oversight forums. Commissioner support for and engagement in the programme of work to address cancer performance issues across GM is essential.

6.3. **Lung Health Checks**

6.3.1. In the wake of notable early work in the City of Manchester, targeted lung health checks are referenced in the NHS Long Term Plan with a commitment to roll out a national programme (subject to successful evaluation of pilot projects in 2023-24). The National Cancer Team is currently supporting 10 projects, one of which is in Tameside and Glossop.

6.3.2. This initiative underpins the goal of improving one year survival and the expectation that by 2028, 75% of cancers will be detected at stage 1 or 2. Lung cancer is the largest cause of avoidable death, typically sees presentation occur at stage 3 or 4 and is presently challenged in terms of delivery of the constitutional standard. However, the work done in the City of Manchester via the Macmillan Cancer Improvement Partnership (MCIP), has demonstrated a stage shift in the early detection of lung cancer and consequently improved outcomes for 1 and 5 year survival.

6.3.3. The following areas have plans for commencing the delivery of LHCs in Greater Manchester in 2019/20:

- In Manchester, the business case for rolling out LHCs to the North Manchester population was approved and this was implemented in April 2019 (1.51% threshold, 55 – 80 years, current and ever smokers)

- NHS Salford CCG approved a business case in December 2018; with a planned start date before the end of Q2 2019/20 (initially planned 3% threshold but amended in light of national direction to <1.51%; age range 55 – 74 years; eligibility criteria smokers, ever smokers, smoking status not recorded on clinical systems)

- NHS Tameside & Glossop CCG was selected as one of the areas funded by the national team to deliver lung health checks as per a national protocol (i.r.o. £6 million over 4 years; 1.51% threshold, 55 – 74 age range)

6.3.4. Whilst there is the opportunity for improved early stage diagnosis and survival, for these populations, this has raised a number of questions regarding the implications from the programmes in terms of increased demand particularly in tertiary treatment services and in primary care, from the need to manage incidental findings. Other questions have been raised regarding inequalities across GM in terms of both access to and the standardisation of the approaches.

6.3.5. Manchester Foundation Trust, as the lung cancer surgery provider, has indicated that it does not presently have the capacity to manage the increased demand generated by three lung health check programmes running concurrently, alongside existing workload pressures from cancer and cardiothoracic surgery and the delivery of associated treatment time standards.

6.3.6. The Christie NHS FT has indicated that the impact of the three programmes would be a doubling of the current demand for Stereotactic Ablation Radiotherapy (SABR). Through enabling SABR delivery on more sites across the network and with further recruitment and training, the Christie is able to accommodate the three programmes. This will require the utilisation of clinical and linac capacity across the network may result in patients needing to access capacity that is not necessarily in a facility closest to the patient.

6.3.7. Other GM areas have expressed an interest in commencing a lung health checks programme but do not currently have funding, or developed plans, although Manchester Health & Care Commissioning has indicated an intention to further roll out the model (subject to a business case) to Central and South Manchester populations.

6.3.8. A Task and Finish Group, chaired by Sarah Price, Executive Lead for Commissioning and Population Health, is in place and it is suggested that the JCB should support the group in delivering the following outputs:

- The development of a single GM model for the provision of the Lung Health Check service, e.g. in terms of thresholds, age range etc. with associated indicative costs for rollout of such a service

- Overseeing the development of a business case relating to secondary care capacity that commands the support of all providers, via joint working with the Provider Federation Board

- Development of potential approaches for wider roll out across GM, recognising the national statement that no further schemes are anticipated until 23/24 pending evaluation of the current schemes

6.4. **Future funding / financial planning**

6.4.1. As outlined earlier in this report, GM Cancer is supporting the implementation of a number of priority projects supported by £10m of Transformation Funding.

6.4.2. Discussions are ongoing regarding potential future funding opportunities for GM to support delivery of the cancer priorities in the Long Term Plan. In preparation for this, localities (CCGs and Providers), Pathway Board clinical leads and Pathway Managers have been asked to put forward proposals for projects. GM Cancer are leading the evaluation of the initial proposals which will be shared with the Cancer Board, who will be responsible for making any investment decisions should funding become available. Proposals are being reviewed against a set of criteria which includes: impact on patient outcomes and experience; delivery of national 'must do' and LTP priorities; impact on patient waiting times; reducing variation.

6.4.3. A more detailed financial assessment of the delivery of the Long Term Plan is underway under the leadership of GM Cancer and the Cancer Board.

6.5. **Resilience of Services in Greater Manchester**

6.5.1. During 2019-20 there have been issues, particularly relating to Breast services, which have illustrated the challenges faced by and impact on the GM system due to the collective action taken to ensure stability of services. In the case of the breast services, it has been necessary to identify short-medium term solutions pending the implementation of a long-term model of provision under the Improving Specialist Care programme.

6.5.2. The GM Cancer Board and JCB discussions in September regarding the current situation with breast services identified the need for oversight through collective governance; and mutual aid and collective action across GM in this specific situation, but also should similar situations arise in the future.

6.5.3. A group with representation from providers and commissioners across GM has met to review the current position and collated a clear action plan to address the issues ahead of a decision on the final model for breast services in GM via the Improving Specialist Care process.

6.5.4. Delivery of the new models of care is essential to ensure long standing 'Improving Outcomes Guidance' (IOG) compliance. This statement applies to services in addition to the breast pathway – for example OG, gynaecology and urology.

6.6. **Rapid Diagnostic Centres**

6.6.1. Rapid Diagnostic Centres (RDCs) are designed to speed up cancer diagnosis and support our ambitions to achieve earlier diagnosis, with improved patient experience, for all patients with cancer symptoms or suspicious results. The Long Term Plan calls for the roll-out of new RDCs that bring together modernised kit, expertise and cutting edge innovation. These centres will begin by focusing on diagnosing patients with non-specific symptoms and who may go to their GP many times before being sent for tests.

6.6.2. NHSE are setting an ambitious five-year vision for RDCs. In time, the intention is that they will offer a single point of access for all patients with suspected cancer. They will offer a personal, accurate and fast diagnosis service, with excellent patient experience.

6.6.3. The development and implementation of RDCs throughout the remainder of 2019-20 is currently being planned as per NHS RDC guidance, but secured funding is fundamental to recruitment and implementation. The GM RDC steering group, chaired by Professor Chris Harrison, is looking to be advised by the GM Cancer Board and GM HSCP with regard to arrangements for the short (2019-20) and long term funding required to deliver the RDC model in GM.

6.6.4. The GM Cancer Board has received interim reports on the implementation of RDCs and will receive further updates at future meetings. Directors of Commissioning and Cancer Commissioning Managers will be closely involved in the ongoing development and delivery of the RDC model in GM.

7. Recommendations

7.1. The Greater Manchester Joint Commissioning Board is asked to note, offer comment / feedback on the content of this report and specifically to:

Acknowledge and support the approach to the development of the cancer element of the Long Term Plan implementation plan by GM Cancer and the GMHSCP

Approve the Terms of Reference for the GM Cancer Board attached at **Appendix 3**

Endorse cancer as a core focus area for the JCB

Formally request a co-designed (provider and commissioner) proposal to address the delivery of the post-diagnosis treatment pathways for the Lung Health Checks model in Greater Manchester, ensuring tertiary capacity is available to support the current 3 models in operation

Acknowledge the current position with regard to LHC delivery in GM – currently only 3 sites – and establish a view on the approach to take in the remaining 7 localities (plus parts of Manchester – Central and South). MFT and The Christie are in favour of the development of a proposal for the delivery of the whole LHC pathway, from assessment to tertiary treatment, for all localities in Greater Manchester. JCB are asked to confirm whether or not they wish to invite the development of such a proposal, based on the national LHC standards and principles, for future consideration.

Agree that via a place-based commissioning approach, localities will undertake further review of the 1, 5 and 10 year survival data, with the objective of addressing the variation across pathways and localities in GM

Support the approach to financial planning – working with finance colleagues in CCGs on a ‘programme budget’ approach to cancer spend, to enable GM to identify the entirety of investment in cancer services

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number **4**

Greater Manchester Cancer

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	28th November 2019	
Title of paper:	Summary of GM results from National Cancer Patient Experience survey 2018	
Purpose of the paper:	This paper is a summary of the GM results from the 2018 NCPES, how we compare to last year's results and how we compare to English results. It includes the key findings where there is good patient experience as well as where we need to improve.	
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 provide the board members with information about cancer patient experience in 2018	
Improved patient experience	The actions detailed in this report will help to make steps towards achieving better patient experience	
Reducing inequality	Reducing inequality for patients across GM is at the core of the GM cancer plan and User Involvement workplan	
Minimising variation		
Operational / financial efficiency		
Author of paper and contact details	**Name: Paula Daley** **Title: User Involvement Team Manager** **Email: paula.daley1@nhs.net** **Name: Chris Repper-Day** **Title: Business Intelligence Analyst: Cancer Intelligence Service** **Email: Christopher.Repperday@christie.nhs.uk**	

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Date: **28th November 2019**
Title: Summary of GM results from National Cancer Patient Experience survey 2018
From: Paula Daley, User Involvement Team Manager and Chris Repper-Day, Business Intelligence Analyst: Cancer Intelligence Service

Introduction

The NCPES is an England wide survey covering all acute and specialist NHS trusts in England that provide adult cancer services. It has been run every year since 2010 and, since 2015, the survey results are published as an Official Statistic.

The survey includes all adult patients (aged 16 and over), with a confirmed primary diagnosis of cancer, who have been admitted to hospital as inpatients for cancer related treatment, or who were seen as day case patients for cancer related treatment, and have been discharged between the months of April, May or June.

The survey is conducted by post with up to two reminders sent to non-responders. Patients can also complete the survey online if they prefer to do so. To maximise equality of access there is a freephone helpline and translation service available. NHSE also conduct a period of field work between October 2018 and March 2019.

51 of the 59 questions relate directly to patient experience. The scores are 'case mix adjusted' based on age, gender, ethnic group, deprivation and tumour group.

A national report is produced and published alongside individual trust and CCG level reports and Cancer Alliance reports were produced for the first time as part of the 2017 survey.

Please note this summary paper relates to the GM Cancer Alliance only and does not include East Cheshire patients.

The Survey

The survey asks 58 questions, grouped into themes:

Topic Areas
1. Seeing Your GP
2. Diagnostic Tests, Finding Out What Was Wrong With You
3. Deciding The Best Treatment For You
4. Clinical Nurse Specialist Care
5. Support
6. Operations
7. Hospital Care As An Inpatient
8. Hospital Care As An Outpatient
9. Home Care And Support
10. Care For Your General Practice
11. Your Overall NHS Care
12. Your Condition
13. About You

Responses

Responses to the National Cancer Patient Experience survey are shown as a percentage of positive response, i.e number of positive responses / Total number of responses

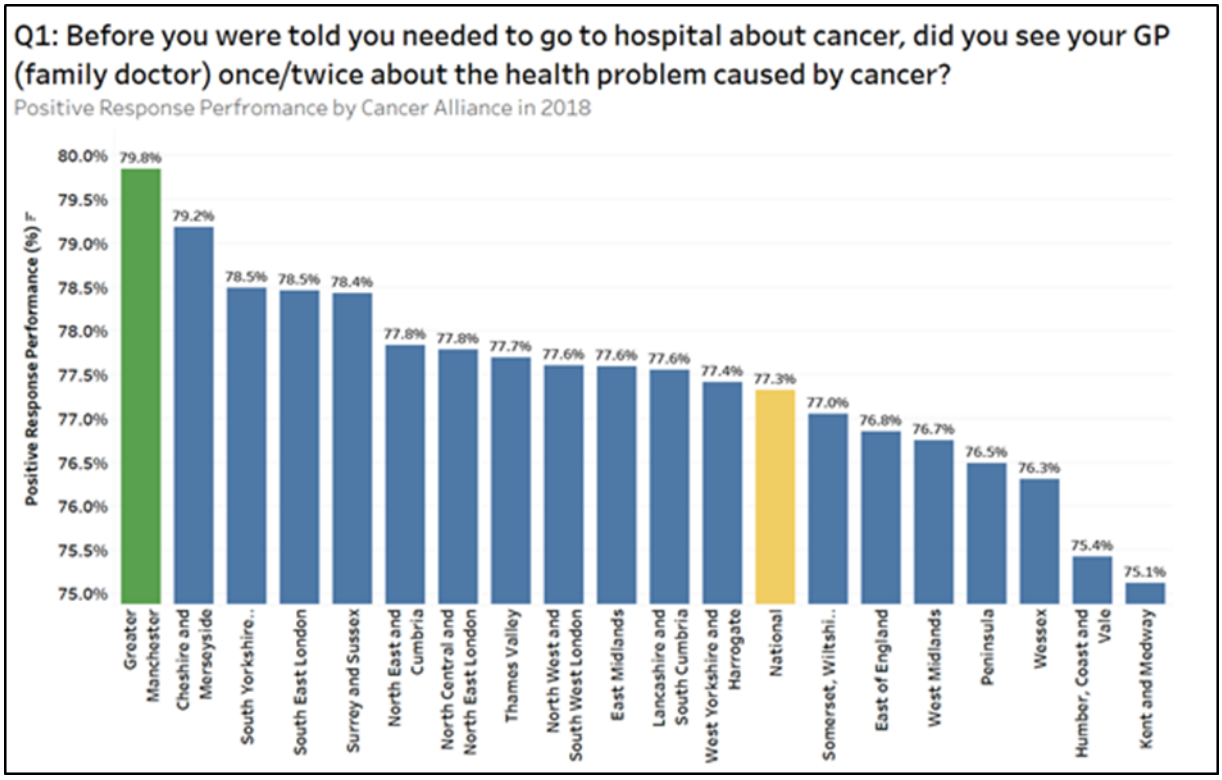
The differences in positive responses from 2017/18 to 2018/19 is that

- 39 questions have increased
- 12 questions have decreased
- 1 question stayed the same

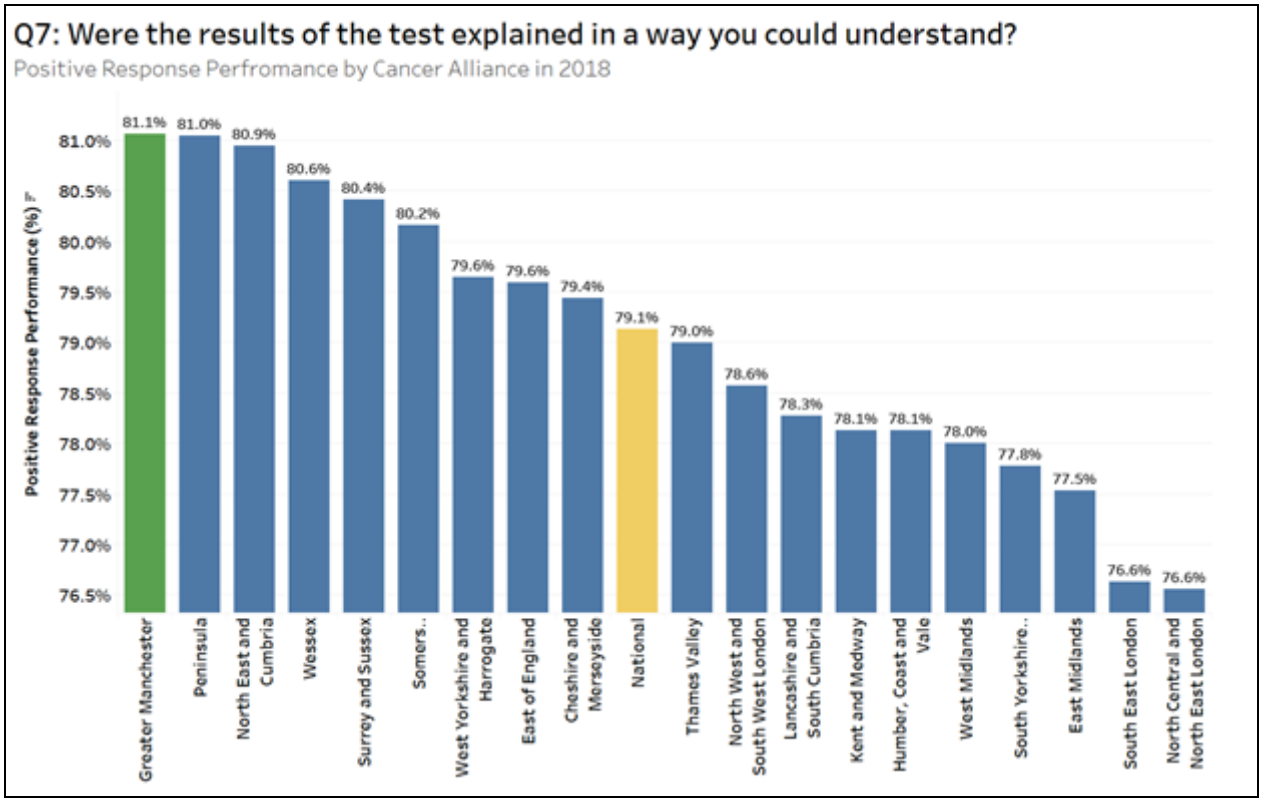
Our best performance

In questions 1, 7, 9 and 44, we exceed the England average and have the best performance of all Cancer Alliances.

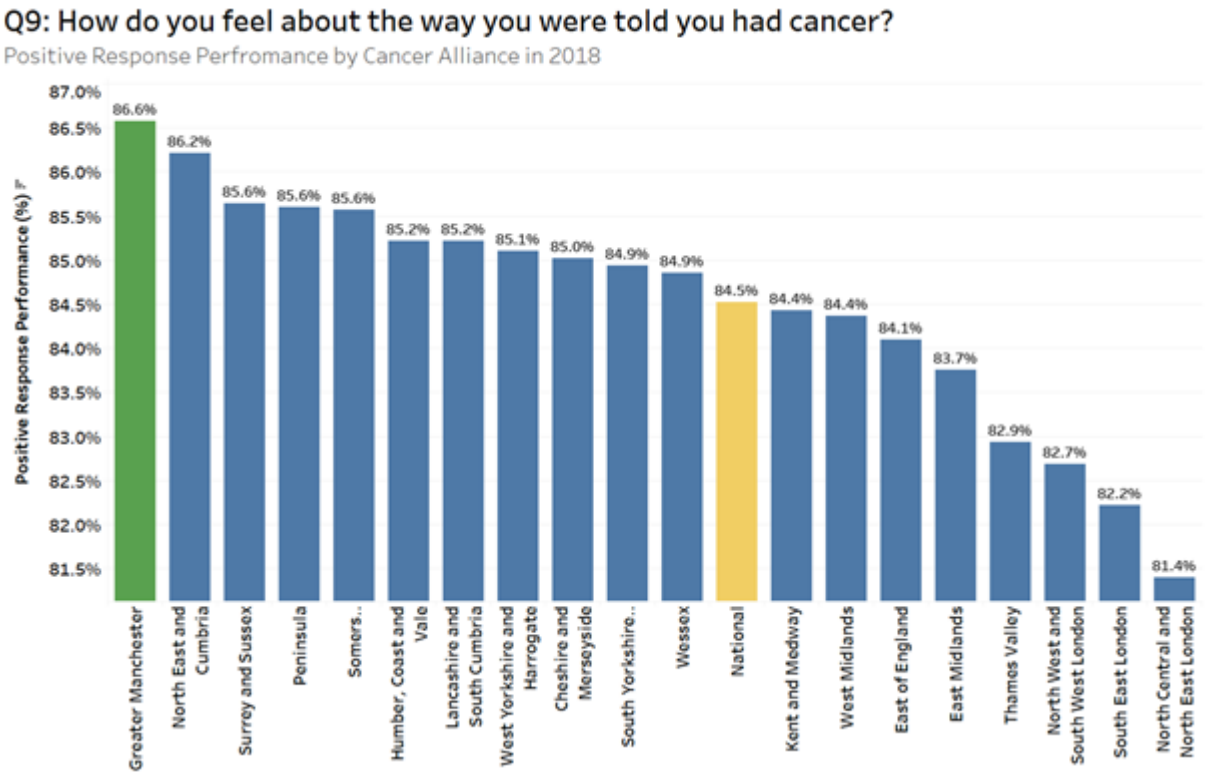
Question 1 relates to number of times visiting a GP before cancer referral. Survey responses showed people visited their GP only once or twice before a cancer referral and our performance improved 1% since 2017 and we are ahead of the England average by 2.5%



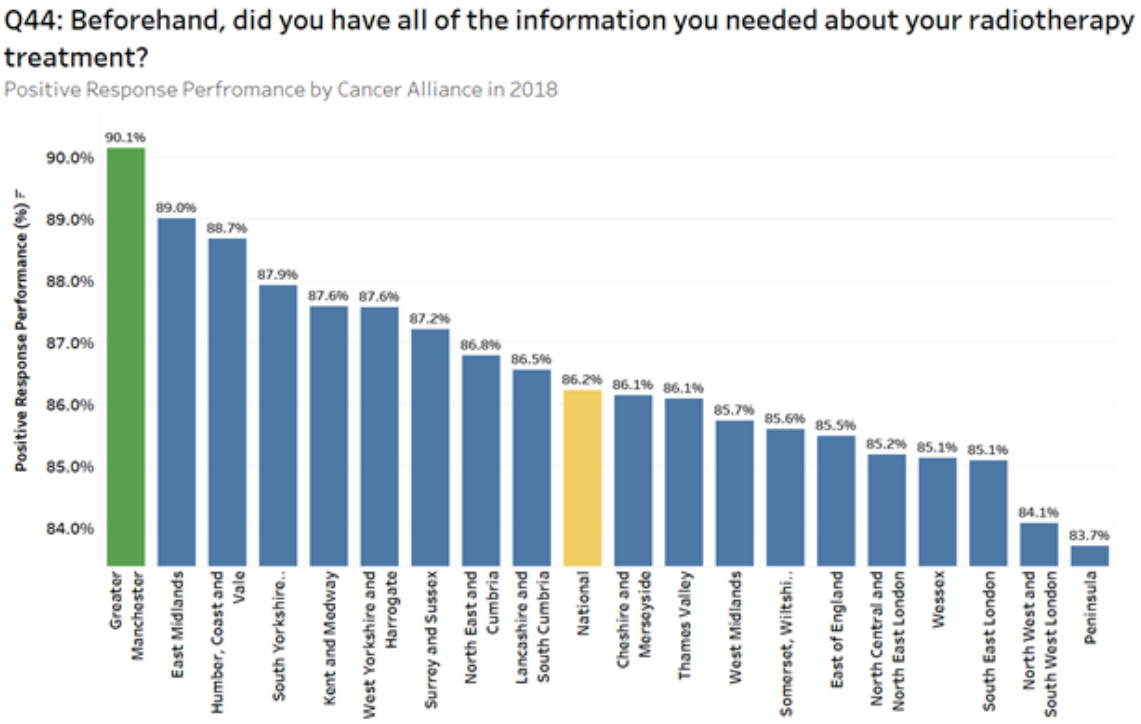
Question 7 relates to how test results are explained. GM performance has increased 0.6% to 81.1%, is higher than the national average and we are ranked the top alliance.



Question 9 asks about the sensitivity with which way people were told they had cancer. Our performance has increased 0.4% since 2017 to 86.6%, we are significantly better than the national average, which is 84.5% and we were ranked the best alliance.



Question 44 asks about information provided about radiotherapy, before treatment. We improved our performance by 1.4% in 2018 to 90.1%, we are significantly better than the national average which is 86.2% and we were ranked the best alliance.



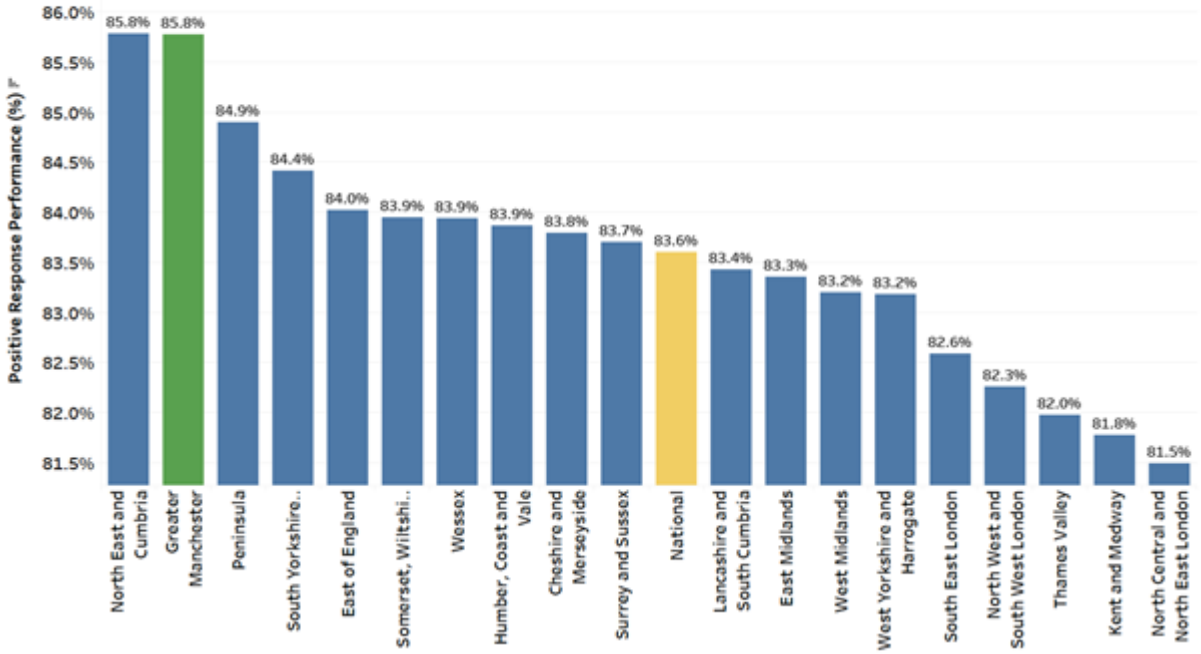
Overall performance

The number of questions in each 13 topic area varies.

There are only two questions in topic 1, 'Seeing your GP' and as shown above we are ranked the best performing alliance in question 1, number of times visiting a GP before cancer referral. Question 2 concerned length of time waiting for first appointment with a hospital doctor. Although GM performance has decreased slightly by 0.1% in 2018, but we are still significantly better than the national average which is 83.6% and we are ranked joint top in this area. An example of a response was to this question is "I was seen as soon as I thought was necessary".

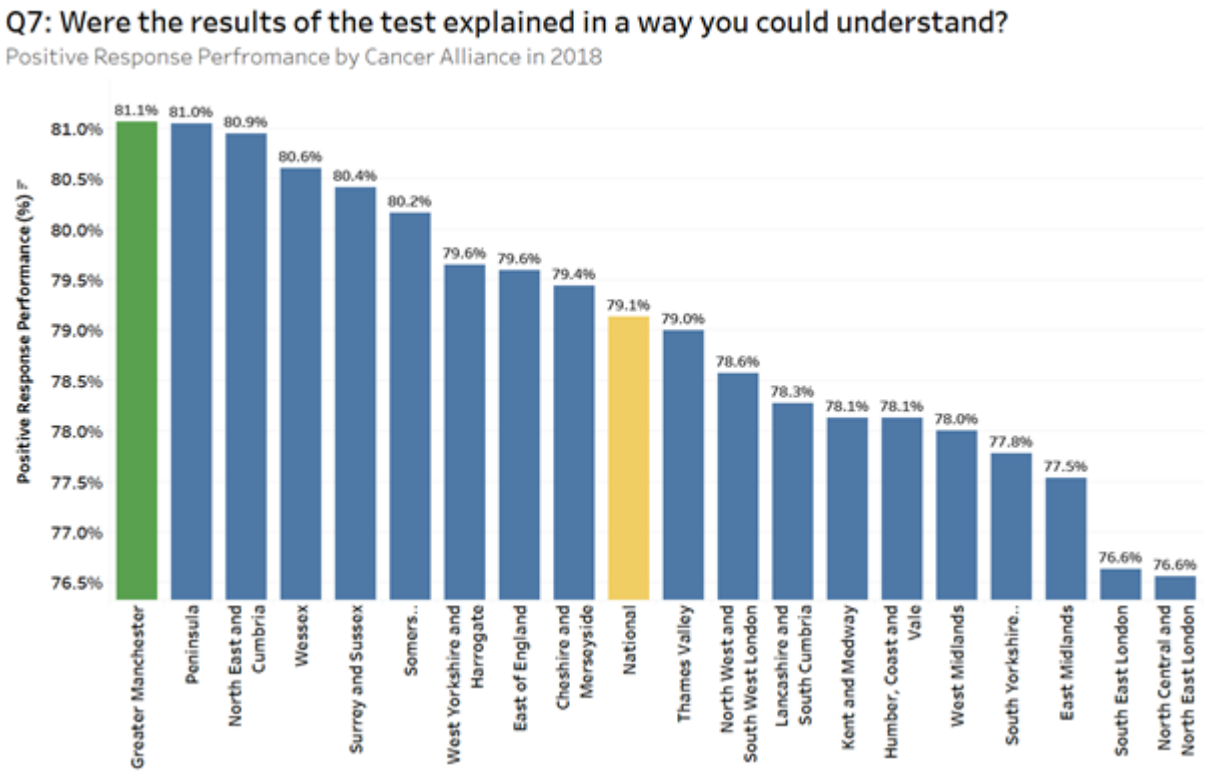
Q2: How do you feel about the length of time you had to wait before your first appointment with a hospital doctor?

Positive Response Perfromance by Cancer Alliance in 2018



As there are only 2 questions in this topic and we are ranked highly in both, it is fair to say we have excellent performance in this area.

In the next topic, Diagnostic tests, patients were asked 3 questions about information you needed beforehand, the length of time waiting for tests to be done and how the test results were explained. We are ranked the top alliance in 2 out of 3 of the questions and are above the national average in all. We improved in 2 out of 3 questions since the last survey, so again we have excellent performance in this area.



The next theme asks about finding out what is wrong and includes question 9, 'How were you told you had cancer' mentioned above.

People were also asked if they had been told to bring a family member or friend to the appointment, if they understood the explanation of what was wrong and given written information.

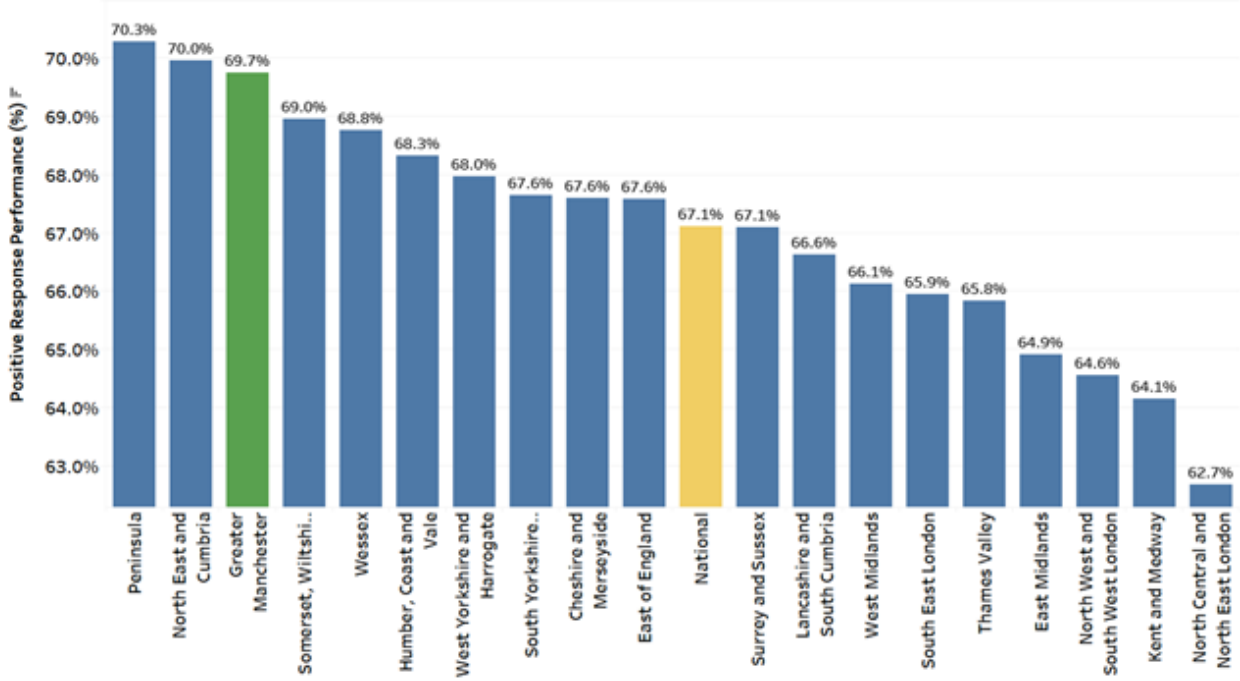
We are above the national average in two of these areas, but in relation to being given written information about the type of cancer, although we performed slightly better than in 2018, by 0.1% to 74.0%, we are slightly below the national average which is 74.5% which suggests there is some room for improvement.

In this topic it is worth noting that a response "Yes, and it was easy to understand" was ranked as positive, whereas "Yes, (I was given information) but it was difficult to understand" is not, hence we may be giving out information but not putting support in place for people to understand what it says.

In the topic, 'Deciding the best treatment for you', five questions ask about how treatment options are explained beforehand, explanations of possible side effects of treatment(s) including future side effects and offers of practical advice and support. We increased our performance in all areas and were above the national average in all. In relation to practical advice and support in dealing with the side effects of your treatment we are ranked the 3rd alliance, increasing our performance by 2.2% in 2018 to 69.7%, significantly better than the national average which is 67.1%

Q14: Were you offered practical advice and support in dealing with the side effects of your treatment(s)?

Positive Response Perfromance by Cancer Alliance in 2018



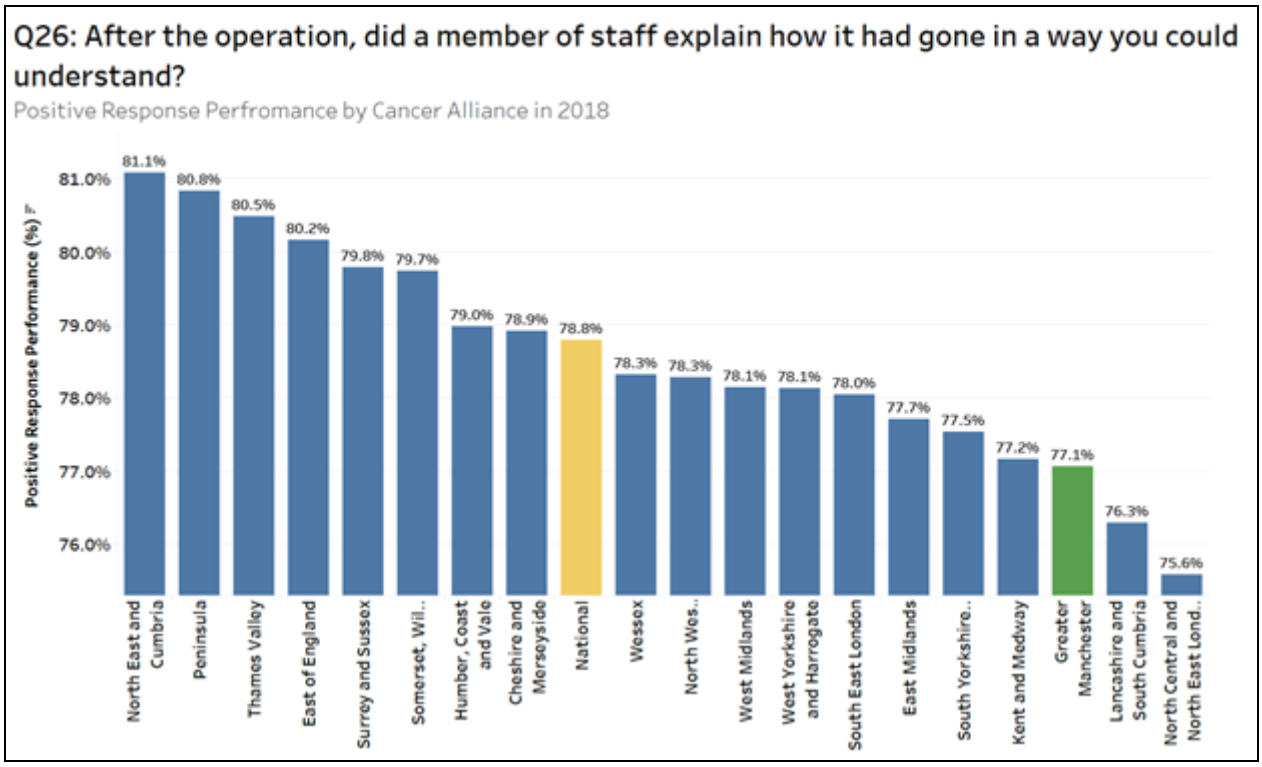
Three questions relate to the Clinical Nurse Specialist (CNS).

Our performance has increased for each question and is above the national average, including how often the patient was given answers they could understand to their important questions where our performance increased by 1.4% to 89.7%, above the national average which is 88.0%. We are performing well in this area.

In the topic about the support available to people when they are told they have cancer, responses to all questions have risen slightly since last year and we're above the national average in all. This includes being given information about support or self-help groups, 87.1%, being told about the impact cancer 84.3%, being told how to get financial help, 62.8% and being told about free prescriptions 82.4%. Although performance in this area is good, being told about financial help available stands out as significantly lower than the other information and support available at 62%. The national average is also notably lower at 60.4%. The implementation of the Recovery Package in GM has shown that of the 55 areas in the Holistic Needs Assessment, 'Money and Finance' is in the top 10 reported concerns. Taken together this would suggest that cancer patients need to be directed to services that can help and support with financial matters.

When asked about having surgery we performed well in giving information about an operation beforehand and we are ranked third in all the alliances, but one of our lowest performing areas in all of the survey relates to how a member of staff explains how the operation went, 'in a way you could understand', where our performance decreased by 1.2% to 77.1%, below the national average of 78%. It is worth noting that a response of "Yes, to some extent" is not counted as a positive. The score of 77.1% relates only to people who felt

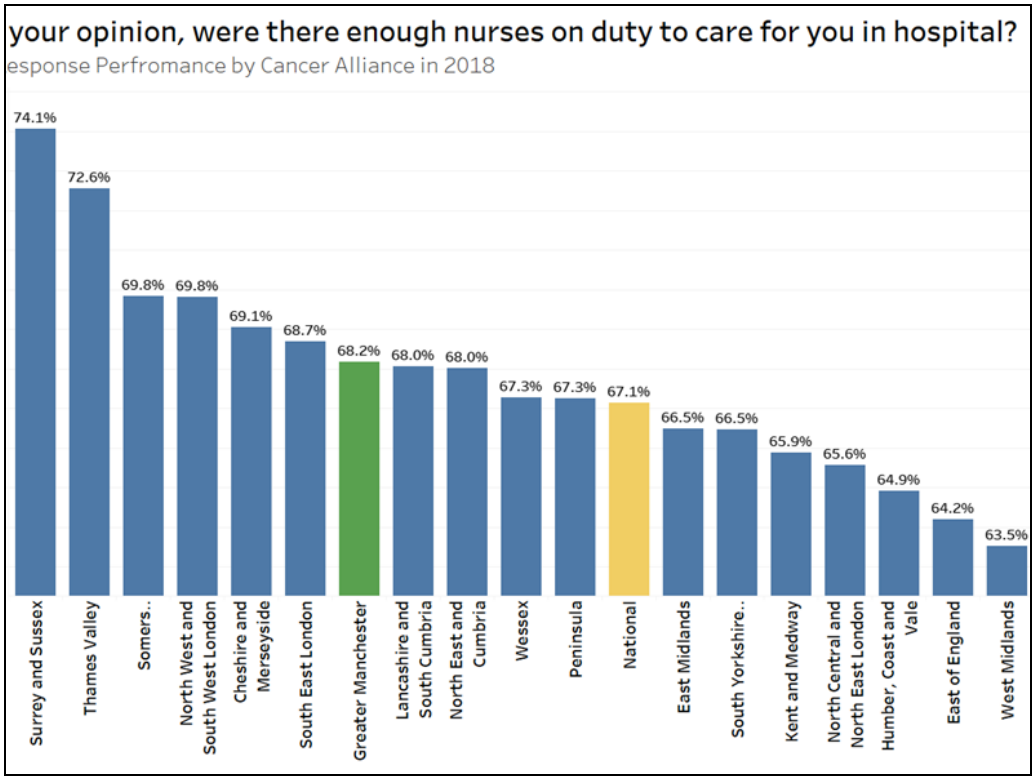
they had had a completely satisfactory explanation about how the operation had gone from member of staff.



Hospital care as an inpatient is a significantly bigger section in the NCPES, containing 12 questions, ranging in subject from confidence and trust in Doctors and Nurses and relatives being able to talk to a doctor, to being treated with respect and dignity and being given clear written information and being told you who to contact after discharge. Our performance increased in ten out of the twelve areas and we are above the England average in nine.

Our biggest increase related to the question ‘were there enough nurses on duty to care for you in hospital?’ Our performance increased by 4.3% to 68.2% which, although not at the high end of the ratings, is above the national average which of 67.1% This would seem to suggest either more nurses are employed or rotas are more efficient.

When asked about having someone at the hospital to talk to about your worries and fears, although our performance increased by 1.8% in 2018 and is above the national average it is still only 54.3%, which requires improvement. The same question in relation to being an outpatient showed better performance with positive responses increasing to 72.6%. This suggests outpatients have access to people to talk to more so than inpatients.



Having hospital treatment as an outpatient also asks about how the appointment is conducted, radiotherapy and chemotherapy. When asked 'did your doctor have the right documents, such as medical notes, x-rays and test results?' 95.5% people agreed, this is slightly below the national average which is 95.6%

In relation to radiotherapy and chemotherapy people were asked about the information they were given beforehand and during treatment.

As mentioned above in 'Our best performance' the information given beforehand for radiotherapy we are ranked as the top alliance at 90.1%.

In contrast, in relation to information given beforehand for chemotherapy, we are ranked as the 3rd worst alliance, with our performance decreasing by 2.9% in 2018 to 82.1%, which is below the national average which is 84.3%

Once treatment started, information given 'in a way you could understand' for radiotherapy patients, our performance also decreased by 1.5% in 2018 to 59.5%. This is only very slightly below the national average (59.6%) Our performance for chemotherapy patients once treatment started, also decreased by 1.0% to 67.7%, which is equal to the national average.

The section Home Care and support is about care and support from health or social services, including information given about these services.

It asks 'were you given enough care and support from health or social services' during and once treatment finished. Our performance decreased by 3.2% to 54.7% for care and support during treatment and 4.4% to 48.7% after treatment.

These are two of the largest decreases in performance within GM from last year, but both remain above the national average. This could indicate that most alliances are struggling with Home Care and Support, but our performance needs to improve in this area.

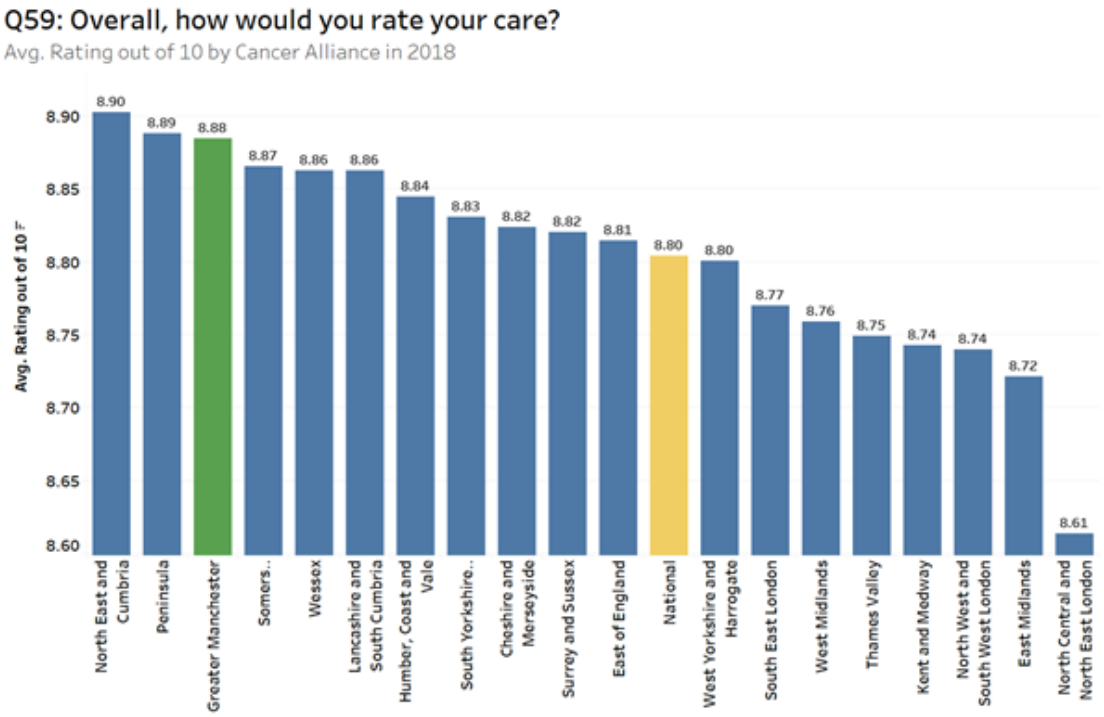
In relation to care from a GP our performance in terms of information about cancer and the treatment has slightly increased in 2018 by 0.6% to 95.3%, which is slightly above the national average of 95.1%. But there is a decrease of 2.1% to 60.9%, in GPs and nurses at general practice 'doing everything they could to support during cancer treatment'. This is still above the national average and we are ranked 3rd against other alliances.

The last six questions were about overall NHS care and including a rating out of 10. The questions asked if different people worked well together, if a care plan was provided and how the whole pathway was administered. Our performance increased in these areas, and was above the national average. However, in relation to being given a care plan, although we are ranked as 3rd amongst the alliances, our performance is still only 39.4%. This is significantly better than the national average which is 35.1% obviously area for improvement for GM and the whole NHS. However, the question which relates to care plans is problematic in that it does not describe what we would understand as a care plan. It states: "A care plan is a document that sets out your needs and goals for **caring for your cancer**. It is an agreement or plan between you and your health professional to help meet those goals". We suspect the wording of the question may impact upon the accuracy of the responses provided.

In relation to the length of time people waited when attending clinics for your cancer treatment our performance improved by 1.8% to 67.9%, but is below the national average which is 69.1%

The final question asked if someone had discussed taking part in cancer research. This is the question we performed lowest on in the whole NCPES, at 32.8%, but the national average is also low at 31.1% and only the London Alliances seem to perform relatively better on this and get up to 43.7%.

Our overall rating out of 10 was 8.88 and we are ranked 3rd among the alliances. Our performance increased very slightly in 2018 and is above the national average of 8.8.



Areas for improvement and action plan

There were seven clear areas from the NCPES where GM Cancer Alliance needs to improve:

- information given about the effectiveness of radiotherapy treatment
- information on services that can help and support patients and their families with financial matters
- availability of someone at the hospital when an in-patient to talk to about your worries and fears
- information given before and during chemotherapy and radiotherapy
- provision of a care plan
- information about care and support available from health or social services during and once treatment finished
- information about the options to take part in research

Patient experience, as captured by the NCPES, is an area that the Macmillan GM Cancer User Involvement programme would be keen to work on, but is currently not resourced to do so. There would need to be a scoping exercise to establish what level of resource was required to pursue this, and it would need to be balanced against current commitments to Pathway Boards and Transformation Projects. We would welcome the Cancer Board's view on this, as well as any other suggestions as to how we patient experience across GM could be improved.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number

5

Greater Manchester Cancer

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	28th November 2019	
Title of paper:	Long Term Plan Update	
Purpose of the paper:	The purpose of this report is to provide Cancer Board with an update on the development of the response to the cancer elements of the Long Term Plan and the programme of work to support its delivery.	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	✓	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes	The paper outlines the delivery of improved patient outcomes in Greater Manchester as set out in the national Long Term Plan (LTP) for cancer.	
Improved patient experience	The delivery of the LTP 'plan on a page' for cancer will improve patient experience for cancer patients.	
Reducing inequality	The delivery of the LTP will reduce inequality by working with localities to a shared prospectus, more open use of data, and including with locality plans the delivery of the LTP for cancer.	
Minimising variation	The delivery of the LTP will reduce unnecessary variation including standardising many areas of practice and developing more single GM cancer services.	
Operational / financial efficiency	There is clear evidence within the report of engagement with appropriate commissioning and CCG finance teams, and information included regarding finance and cancer services.	
Author of paper and contact details	**Name:** Claire O'Rourke **Title:** Associate Director – GM Cancer **Email:** claire.orourke@christie.nhs.uk	

Delivering the Long Term Plan 2020-2023/4: Cancer

8. Background and context

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

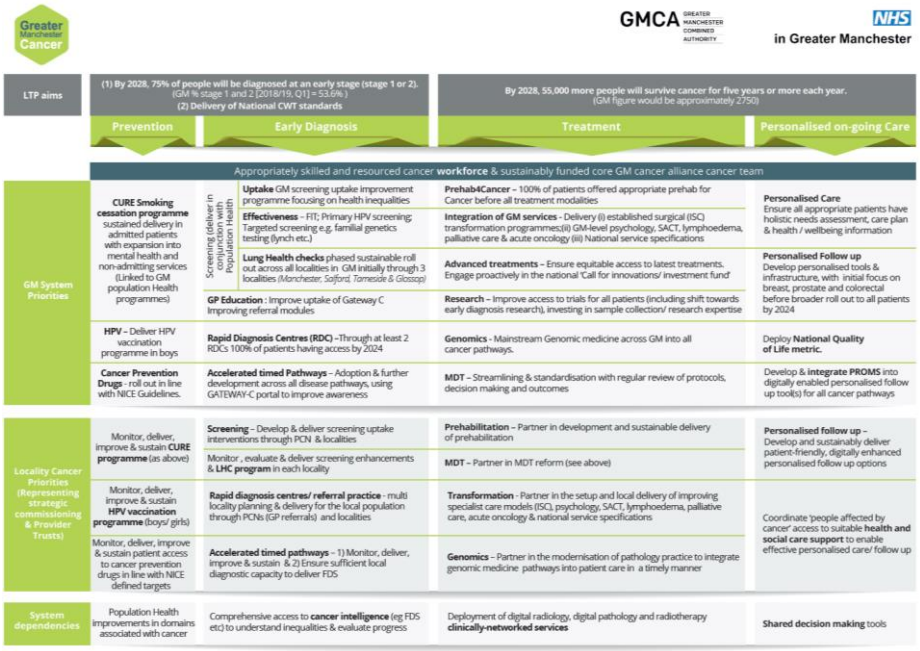
- By 2028, 55,000 more people will survive cancer for five years or more each year;
- By 2028, 75% of people will be diagnosed at an early stage (stage one or two)

8.2. The NHS Long Term Plan (LTP) Implementation Framework, issued in June 2019, states that '*Local systems should engage with their Cancer Alliances to set out practically how they will deliver the Long Term Plan commitments for cancer over the next five years including on early diagnosis and survival, while improving operational performance through interventions*' by:

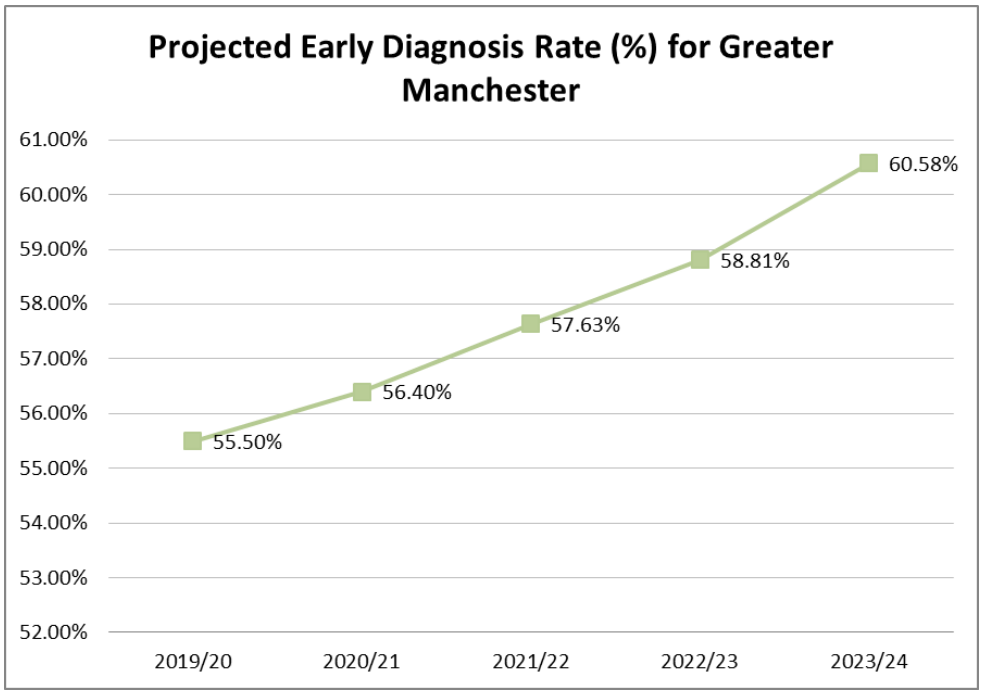
- Improving one year survival rate
- Improving bowel, breast and cervical screening uptake
- Roll-out of FIT for symptomatic and non-symptomatic populations in line with national policy, and HPV as a primary screen in the cervical screening programme
- Improving GP referral practice
- Implementation of faster diagnosis pathways
- Improving access to high-quality treatment services, including through roll out of Radiotherapy Networks, strengthening of CYPs Cancer Networks and reform of MDT meetings
- Roll out of personalised care interventions, including stratified follow-up pathways, to improve quality of life

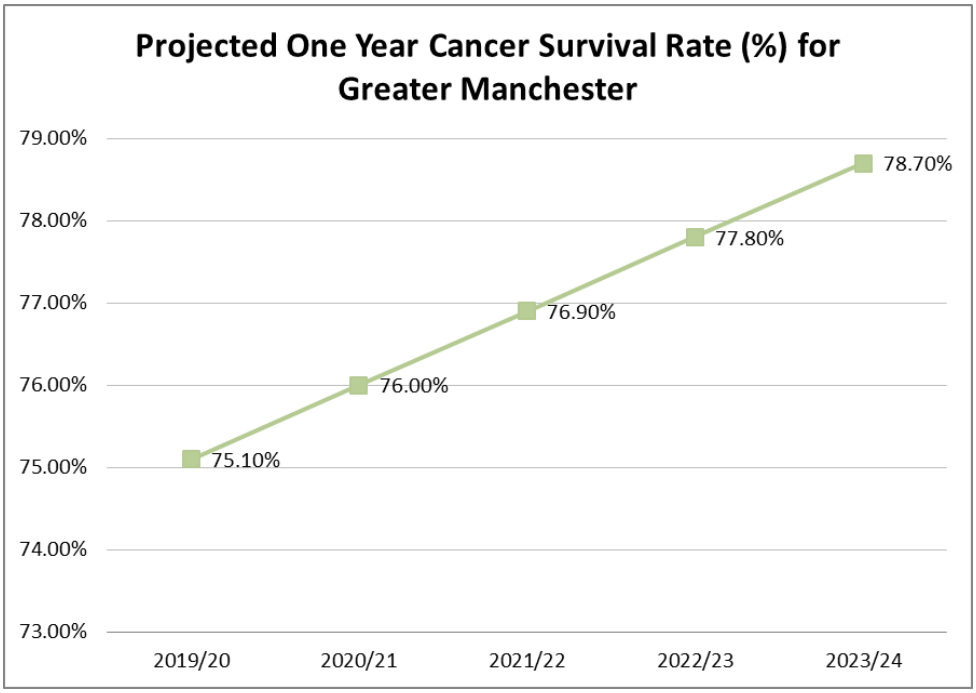
9. Progress Update

9.1. GM Cancer, as the Cancer Alliance for Greater Manchester and as part of the GM Health & Social Care Partnership, has led the development of the response to the Long Term Plan and is establishing a programme of work to support its delivery. A 'plan on a page' version was approved by the Cancer Board on 16th September and submitted, along with the detailed plans, to the Partnership. The 'plan on a page' is shown below and attached at **Appendix 1.**



9.2. Trajectories have been developed, in line with Cancer Alliance guidance and NHS LTP expectations, to show the GM position against 1 year survival and early diagnosis (stage 1 and 2). The graphics below show the expected progress towards improving 1 year survival, and early stage diagnosis. These have also been submitted to NHSE/I and to the GM Health & Social Care Partnership.





9.3. GM Cancer Senior Management Team representatives have been (and will continue to be) involved in the GMHSCP events relating to the 2020-2023/4 planning processes, ensuring the Alliance are submitting the information required for the cancer programme across GM, but also to ensure awareness of and engagement in locality activities relating to planning and the re-write of the locality plans.

9.4. A report is to be presented to the GM Joint Commissioning Board Executive in December to outline the approach to the commissioning of cancer services in GM and the development and delivery of the Long Term Plan in relation to Cancer.

10. Investment in Cancer in GM: Finance and the Long Term Plan

10.1. The GM Cancer Senior Management Team have undertaken an initial review of the LTP submission with a view to determining the financial investment required to deliver all elements of the plan between 2020/21 and 2023/24. This work will continue to ensure a fully costed plan is developed to indicate the required investment to 2023-24.

10.2. Discussions are ongoing with GMHSCP with regard to future funding for GM Cancer (as the GM Cancer Alliance) and investment in cancer services in GM.

10.3. Discussions are to take place via Provider Federation Board re the funding of the GM Cancer core team.

10.4. Cancer Board members are asked to note the content in the JCBE report with regard to programme budgeting and the existing investment, and the need to use existing (including the current transformation funding) and any potential additional investment to mitigate the impact of the expected increase in demand for cancer diagnostics and treatment.

11. Summary & Recommendations

11.1. The Cancer Board are asked to note the development to date of the response to the LTP for Cancer and alignment to GM and NHSE/I planning timescales and processes.

11.2. The Cancer Board are asked to note and support the work on the development of a fully costed delivery plan to support the existing LTP documents and submissions.

11.3. Members are asked to read this report in the context of the JCBE report, which has also been shared for information and comment, particularly the section in the JCBE report relating to the challenges and key issues.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number **6**

Greater Manchester Cancer

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	28th November 2019	
Title of paper:	Greater Manchester Cancer workforce report	
Purpose of the paper:	This paper presents a refresh of the 2018 Greater Manchester cancer workforce review, key findings following an initial scoping exercise undertaken by the cancer workforce lead and recommended areas of priority for 2020/2021.	
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 key workforce challenges across Greater Manchester and areas of focus to support implementation of the long term plan priorities detailed in the GM Cancer plan. The overarching aim of the plan is to improve outcomes and patient experience, and reduction in variation across GM.	
Improved patient experience	Ensuring the NHS workforce has the right numbers, skills and values to implement the Long term priorities is key to improving outcomes, access and reducing variation - two key factors in patient experience. The actions detailed in this report will help to make steps towards achieving this.	
Reducing inequality	Reducing inequality for patients across GM is at the core of the GM cancer plan and supporting workforce plan, which will be developed in more detail following this report.	
Minimising variation	As improved outcomes above	
Operational / financial efficiency	Making improvements in cancer outcomes by addressing workforce issues will support the delivery of the financial and operational efficiencies described in the GM Cancer Plan.	
Author of paper and contact details	**Name:** Suzanne Lilley **Title:** GM Cancer workforce lead **Email:** Suzanne.lilley2@nhs.net	

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Date: 28th November 2019

Title: **Greater Manchester Cancer workforce report**

From: **Suzanne Lilley, Greater Manchester Cancer workforce lead**

Context and purpose

1. To ensure the NHS has the right number of skilled staff to provide high quality care and services to people affected by cancer (PAbC) Health Education England (HEE) developed the National Cancer Workforce Plan (CWP) phase 1 in partnership with NHS England (NHSE), published in 2017. To support implementation of this, Greater Manchester (GM) cancer coordinated a system wide workforce review in 2018, which provided baseline figures for each of the seven key professions referenced in the CWP, projected future demand over the next five years and captured mitigating actions to address the gaps (attached as Appendix 1).

2. The key findings presented in this paper support several reports commissioned by Cancer Research UK (CRUK), which identify the significant and growing capacity gap in key diagnostic services – imaging, pathology and endoscopy – as well as non-surgical oncology services. CRUK has also identified some of the major shifts in cancer diagnosis and treatment which are likely to impact on the cancer workforce in the future, in the paper 'Securing a cancer workforce for the best outcomes'. Many of these were highlighted in research conducted as part of this report, including changes to screening programmes, new technologies such as molecular diagnostics, and the introduction of new treatments.

3. Improving cancer survival through earlier diagnosis is a key priority in the Long Term Plan (LTP), published by NHSE in 2019. GM Cancer has responded to these ambitions by providing a five year implementation plan, summarised at the cancer board in September (attached as Appendix 2). The GM plan identifies workforce as a cross cutting dependency without which the ambition will not be met.

4. This paper presents a refresh of the 2018 GM cancer workforce review, key findings from an initial scoping exercise conducted by the GM Cancer workforce lead (CWL) and recommended areas of priority for 2020/2021.

Stakeholder engagement

5. The CWL has been in post since August 2019, and as part of the initial scoping exercise has engaged with a variety of stakeholders throughout September and October to understand current workforce challenges to help identify priority areas that will impact on delivery of the GM strategy to improve earlier diagnosis and survival rates.

   The table below summarises engagement at each trust:

Provider trusts	Cancer manager	Commissioning manager	Director of Ops	Rad. Manager	Path. Manager	Gastroenterology	Lead cancer nurse	HR
Bolton		✓	✓	✓	✓		✓	
East Cheshire	✓	✓	✓		NA	✓	✓	✓
MFT	✓	✓	✓	✓	✓	✓	✓	✓
Pennine	✓	✓	✓	✓	✓	✓	✓	
Salford	✓	✓	✓	✓	✓	✓	✓	
Stockport	✓	✓	✓	✓	✓	✓	✓	
Tameside & Glossop	✓	✓	✓	✓	NA		✓	
Wigan, Wrightington and Leigh (WWL)	✓	✓	✓	✓	✓	✓	✓	
The Christie	NA	NA				NA	NA	✓

6. Further engagement has taken place with regional partners, third sector partners, the Greater Manchester health and social care partnership (GMHSC) and via the GM Cancer pathway boards. This included engaging with the clinical leads overseeing system plans for pathology and radiology; Getting it right first time implementation team (specifically in relation to the radiology workstream); NHSE; NHS Improvement (NHSI) regarding pathology networks; HEE regional and national teams; CRUK / Macmillan; and other alliances (South Cumbria and Lancashire, South Yorkshire, London).

Key findings

7. The key findings will be presented against each of the seven key professions referenced in the cancer workforce plan in addition to other wider areas of the workforce that need to be considered if the long term plan ambitions are to be achieved.

8. There are limitations with the data presented due to a number of confounding variables: all of the professions in the CWP apart from oncology work across domains and so it is difficult to accurately calculate capacity purely dedicated to delivering cancer services; limits on pension tax relief can result in misleading data i.e. number of PAs have reduced causing capacity issues however, this is not reflected when presenting the WTE; the methodology by which trusts have calculated WTE's has not been standardised i.e. some may have included all radiologists, others may have calculated WTE based on % of their time allocated to purely delivering cancer services; the data is incomplete as some trusts were in the process of conducting workforce reviews so did not have up to date data. However, the difficulty and lack of consistency in approaches to recording workforce data is in itself an important note to make and something that needs further exploration if we are to plan accurately for our future workforce. Although not complete, the data has been included to complement the narrative and highlight current gaps in order to prioritise.

9. There are a number of cross cutting themes which could impact on delivery of the LTP ambitions including a significant % of senior staff nearing retirement age in the next few years, limits to the pension tax relief, dedicated time to focus on horizon scanning / succession planning, high vacancy rates, Brexit implications, geographical barriers – some areas are not as desirable or unable to compete with the career development packages offered by other trusts and so they are not attracting candidates. This adds further to pressure to the existing workforce, and can lead to high levels of competition within the region.

10. Across all of the pathways there has been an increase of 14.3% in two week wait referrals (2WW) in the past year and 8.8% in actual activity (number of patients on the 62 day pathway) which is greater than the NHSE assumed activity increase of 7%. The growth of the cancer workforce is not keeping pace with the demand.

11. Diagnostics is clearly a priority area for GM as it is nationally. The Royal College of Radiologists 2018 UK census report highlights the increasing demand for diagnostic radiology services, and how *'vacant consultant posts cannot be filled, and expenditure on outsourcing, insourcing and locums is spiralling*'. There is currently no diagnostics strategy in place for Greater Manchester and there has not been a system wide review of the diagnostic workforce, numbers needed / workforce transformation required to meet this increase in demand and to support future growth. There has however, been progress in other areas and future plans, which will have an impact on capacity, to be discussed later in the paper.

12. **Histopathology and healthcare science:** is thought to be one of the biggest pressures impacting on the timely delivery of cancer diagnoses.

    The table below presents the most recent figures submitted by providers, vacancy rates and projected demand over the next five years:

Trust	Histopath (WTE)	funded posts (vacancy rate %)	Trust 5 yr Forecast (WTE)	Gap (WTE)	Healthcare scientists (WTE)	funded posts (WTE)	Trust 5 yr forecast (WTE)	Gap (WTE)
Salford	14.5	17.5 (17%)	21.5	7	36.54	34.03 (0%)	40	3.46
MFT	26.66	31.91 (16%)	34.14	7.48	48.77	54.52 (11%)	58	9.23
Pennine	9.4	13.8 (32%)	18	8.6	38.15	29.12 (0%)	40	1.85
Stockport	7.6	9.2 (17%)	8.2	0.6	20.21	20.45 (1%)	20.45	0.24
Bolton	5.5	6.5 (15%)	7.5	2	13.5	13.7 (1%)	16.2	2.7
The Christie*	9	no data	9	0	no data	no data	no data	NA
TGH	provided by MFT							
WWL	Joint service w. Salford							
East Cheshire	Managed by mid-cheshire							
Total	**72.7**	78.91 (incomplete)	**98.34**	25.68	**157.17**	151.82	**174.65**	17.48

*2018 data, 2019 data under review

The projected gap in the 2018 review was vast (58.45WTEs) however, recent figures from the HEE e-workforce submissions suggest that this gap has reduced significantly. The data above suggests that there will be a total gap of 25.68WTE consultants across GM over the next five years. Vacancy rates average at 19% across GM, which reflects the national shortage of trainee histopathologists coming through the pipeline, and supports feedback from trusts around difficulties recruiting. This results in high levels of competition across the region. To add to this pressure, workload has increased due to additional screening programmes such as the Faecal Immunochemical Test (FIT) for bowel screening, growth of molecular pathology, and increases in complexity of pathology testing. This increase in volume and pressure to meet the faster diagnosis standard has resulted in significant delays and a high number of breaches for some trusts.

To help meet the extra demand some trusts have had to over-rely on outsourcing services, which can impact on waiting times, as high as 4 weeks in some instances (majority of trusts do not outsource non-routine (cancer) work), and locum costs are high, adding financial pressure.

Increasingly healthcare scientists (HCS) are being upskilled to support dissection and reporting however, there are also predicted gaps in the HCS workforce going forward. A further 17.5WTE HCS will be needed across GM to meet demand over the next five years to deliver long term plan ambitions and best possible care for PAbC.

This mirrors the findings of a 2016 national report on pathology capacity by CRUK, which concluded that there is likely to be a crisis in pathology capacity within five to ten years. This is because staffing levels have not kept up with demand caused by increasing incidence, increasing complexity and efforts to diagnose cancer earlier.

13. **Radiology:** discussions with radiology managers across GM and East Cheshire (EC) and the GIRFT implementation manager leading the deep dive sessions with GM trusts, revealed similar issues to those mentioned above.

    The table below summarises current staff in post, vacancy rates and five year forecast for clinical radiologists and diagnostic radiographers.

Trust	Clinical radiology (WTE)	funded posts (vacancy rates)	Trust 5 yr forecast (WTE)	Gap (WTE)	Diag. Rad (WTE)	funded posts (vacancy rates)	Trust 5 yr forecast (WTE)	Gap (WTE)	% work being outsourced
Salford	27.26	30.26 (10%)	45.26	18	71.47	70.77	138.2	66.73	7% (cancer)
Mft	59.4	66 (10%)	80	20.6	208.3	No data	220	11.7	0
Pennine	21.57	32.7 (34%)	42.70	21.13	130.66	142.94 (9%)	163.94	33.28	7% (cancer)
TGH	4.45	No data	Under review	NA	69.02	No data	Under review	NA	yes, none urgent
WWL	15.4	17 (9%)	Under review	NA	98.85	107.41 (8%)	Under review	NA	yes, none urgent
Stockport	18.61	15 (0%)	25.31	6.7	39	45.64 (15%)	57.59	18.59	yes, none urgent
East Cheshire	8.65	8.65 (0%)	10.65	2	22.88	25.09 (8.8%)	28.65	5.77	yes, none urgent
Bolton*	13.33	no data	19.89	6.56	68.58	no data	97.2	28.62	3% of routine work**
The Christie*	21	no data	30	9	47.1	no data	51	3.9	no data

*2018 data
**current data

Imaging is a vital modality in the diagnosis and treatment of cancer. Demand for imaging has been increasing significantly in recent years and is likely to continue to increase in the future, due to a number of factors including increasing cancer incidence, higher rates of referral for imaging, direct access to imaging, and the increasing complexity of images. New approaches such as Targeted Lung Health Checks (LHCs) being rolled out in GM, has also increased demand with the imminent Rapid diagnostic centres (RDCs) forecast to add further pressure.

Current vacancy rates across GM and EC (using the data available above) are 11% for consultants and 7% for radiographers. The anticipated demand over the next five years leaves a total gap of 83.99WTE (average gap of 12WTE) and 168.59WTE (average 24WTE) for consultants and diagnostic radiographers respectively. The predicted gaps have increased significantly when compared to the gaps forecast in 2018 (27.25WTE and 146.51WTE respectively). Radiology capacity was frequently raised at various pathway boards as one of the critical factors impacting on performance targets leading to delays in reporting of up to four weeks.

Training can be a limiting factor as trainee numbers on radiology courses are limited by placement capacity in trusts. To expand capacity, placement sites need expanding.

Outsourcing is high due to significant backlogs. In the main, this is for routine work however, as the table reports above outsourcing of non-routine cancer work is increasing.

The picture is variable across the different trusts, some remain to have high vacancy rates / high agency costs. However, compared to pathology services there has been a considerable amount of investment internally and from HEE to try to close some of the workforce gaps. This includes investment in reporting radiographers to free up consultants to do the more complex reporting.

There still remains a shortage in clinical radiologists, diagnostic radiographers and sonographers, which results in issues with cover for annual leave / sick leave with the potential to impact on service delivery. Some trusts are unable to increase numbers of newly trained radiographers as they have too few consultants to supervise new trainees and therefore remain in deficit.

Further work is needed to understand gaps and challenges relating to the sonography workforce as they can often get overlooked, sometimes being classified with radiographers, advanced practitioners or reporting radiographers despite having a distinct and important role to play in cancer diagnosis.

Regarding therapeutic radiography, this is provided by The Christie who reported no issues with this profession in 2018. However, The Christie did identify an anticipated 106WTE gap over the next 5 years due to a number of factors that could create barriers in the future. These include the introduction of student fees impacting on recruitment to post graduate radiotherapy courses; the growth of private radiotherapy potentially attracting Therapy Radiographers to non NHS positions; the expansion of services including the development of an additional satellite and the advent of the first high energy Proton centre in the UK. The Therapy Radiographers workforce will be impacted by changes in demand for and shortages in supply of related professions, e.g. Therapy Radiographers will displace Clinical

Oncologists from some elements of the patient pathway and will replace Clinical Scientist / dosimetrists in some of their roles.

One final consideration is the need to have dedicated administrative support for Radiology to reduce request to scan times and expedite follow up tests such as biopsies and Fine Needle Aspirations that require day case beds or consent, which all requires more co-ordination than standard imaging tests. This type of support varies across trusts.

14. **Medical and clinical oncology:** engagement with the oncology workforce has been limited due to a high % of oncology services at provider trusts being provided by The Christie and therefore oncologists are not employed by the trust. However, the workforce review in 2018 highlighted an anticipated gap of 8.75WTE in the next 5 years and a number of key challenges including difficulty in recruiting to acute oncology posts, recruitment and retention of posts which include split site working where there are limited opportunities to offer clinical trials at peripheral sites, which is a core component of Medical Oncology training and expertise.

    Another significant challenge within Medical Oncology is the high ratio of consultants to registrars resulting in insufficient middle-grade support in each disease group. This is further compounded by the requirement for SpR rotas to provide greater out-of-hours cover for inpatient care, thereby reducing availability of SpRs during core hours for routine work where the majority of Medical Oncology treatment activity is delivered in the ambulatory setting. Recruitment to non-training middle-grade posts can be difficult especially for peripheral sites where the need is greatest.

    Clinical Oncology: recruitment to SpR posts is a challenge and registrar numbers are disproportionately low compared to consultant numbers. Ensuring all numbered posts are filled would improve the position for Clinical Oncology. As the seven day services agenda progresses, the need for additional middle-grade posts is likely to increase.

    Additional issues were raised by the peripheral sites including lack of service level agreements between the trusts and The Christie resulting in poor representation at MDTs and lack of cover for annual leave.

    Research into the oncology workforce conducted by CRUK in 2017 found that vacancy rates in oncology may be underestimates of the true workforce gap because long-term vacancies have a bigger impact on a service and because services are unlikely to advertise posts they are unable to recruit to, even if they are required. Across the workforce it was found that as well as meeting current capacity, there are significant changes in treatments, technology and treatment delivery which will have an impact on the oncology workforce. The impact of earlier diagnosis on the treatment workforce needs to be further explored – for example what will be the impact on the oncology workforce of achieving stage shift in lung cancer through the Targeted LHCs.

    Haemato-oncology: there are national concerns about this workforce with the demand for posts anticipated to increase steadily over the next 5 years. Year on year there is an increase in activity as a result of new treatment options leading to better survival, increased referrals from District General Hospitals unable to manage complex treatments, increase in elderly population in UK, improved diagnostics and more patients being able to receive complex treatments.

Recruitment can be challenging as there is a limited number of trainees finishing and there is the impact of many consultants wishing to opt for flexible working, retiring.

15. **Gastroenterology**: the following table outlines current numbers of gastroenterologists and endoscopy capacity, vacancy rates and projected demand:

Trust	Gastro (WTE)	funded posts (vacancy rates%)	Trust 5 yr forecast (WTE)	Gap	Endo (WTE)	funded posts (vacancy rates%)	Trust 5 yr forecast	Gap (WTE)	% work being outsourced
Salford	10.8	10.8 (0%)	11.8	1	3	3.5 (14%)	Under review	NA	0
MFT	32.5	34.20 (5%)	No data	NA	unclear	-	-	-	-
Pennine	14.31	15.58 (8%)	16.58	2.27	4.76	4.76 (0%)	7.76	3	39% of all endo activity (mixture of cancer /routine)
TGH	4	No data	5	1	2	No data	3	1	no data
WWL	11.3	11.3 (0%)	unclear	NA	3	4 (75%)	no data	NA	0
Stockport	7	8 (13%)	8	1	28.87	30.95 (6.7%)	40.91	12.04	0
East Cheshire	2	3 (33%)	4	2	1.4	1.4	2.4	1	Adhoc additional sessions for Endo
Bolton*	6.2	No data	6.62	0.42	No data	No data	No data	No data	No data
The Christie	no gastro dpt								

*2018 data

The data collected above suggests an overall vacancy rate of 6% across GM and EC with consultants being particularly challenging to recruit, and with an ageing workforce this will leave further gaps over the next five years.

There was limited data on the endoscopy workforce however, it has been raised as an issue, being cited as one of the biggest causes of breach for gastroenterology by one trust. This is due to the general increase in activity and rollout of FIT. One trust has had to outsource services to a private provider due to being unable to meet demand.

There has been a shift to upskilling the nursing workforce to nurse endoscopists however, due to such short supply, retention is a challenge. Length of training and lack of capacity to supervise newly trained endoscopists have been cited as barriers.

16. **Nursing (CNS):** The table in appendix 3 highlights current numbers of cancer CNS (band 6+) across key pathways in GM and EC, projected numbers needed to meet the 7% assumed increase in activity (NHSE) and the actual increase in activity seen in GM over the past year. The table does not take into account the number of support roles currently in place such as navigators, cancer support workers however, this needs to be considered when looking at projected numbers going forward.

    There is currently a total of 266.1WTE of CNS working in cancer services with a vacancy rate of 2.9%. This has reduced from the 4% referenced in the Macmillan census (2017) however, there are other factors to consider. Although posts are being filled, they are not being filled by CNS. Numbers are not coming through the pipeline in the volume needed to meet demand and there is no clear career framework to 'grow your own'. As a result trusts are filling posts with candidates who do not have the experience required and require a lot of training up on job, creating extra pressures for an already overstretched workforce.

    Interestingly, for some pathways such as the urology cancer pathway, the increase in number of 2WW referrals is significantly lower than the overall average increase between 2018 and 2019 (6.85% vs 14.3%) however the increase in actual activity is significantly higher (15.9% vs 8.8%) suggesting an increase in the quality of referrals coming through / higher number of appropriate referrals. This information will be shared with the pathway boards to look at this data further.

    Based on the data collected across GM and EC, the projected numbers of CNS required to meet the increased activity is slightly higher than numbers projected by NHSE (7% activity assumption) – an additional 21.76WTE compared to 18.45WTE.

    Feedback from lead cancer nurses across GM and EC reflect findings in the Macmillan census and Voices from the frontline (2019) reports highlighting a lack of support for training and development, which is often why nurses leave the profession, and an ageing workforce with 72% being over 40 years of age, 39% 50yrs+ with limited evidence of succession plans in place to fill these imminent gaps.

Other areas to consider outside of CWP

17. **Screening and immunisation programmes:** new screening programmes whilst improving early diagnosis have put a considerable amount of pressure on the rest of the system. As mentioned the rollout of FIT has resulted in a spike in referrals but then due to the existing colonoscopy capacity issues, there is a delay to diagnosis. There are also capacity issues with specialist screening practitioners, with few coming through the pipeline.

Breast screening: there is a current shortage of mammographers with screening mammographers being pulled to deal with symptomatic patients. The closure of the Stockport service has put pressure on the rest of the system and as a result GM Cancer and the partnership have been working with providers to look at future proofing breast services across Greater Manchester.

LHCs: following the rollout of LHCs in three localities the increase in volume of referrals has impacted on the whole pathway. Radiology and histopathology workforce issues described above impact PAbC by causing delays to CT scans / reporting, biopsy / reporting and the increase in activity has also impacted on treatment with radiotherapy and surgical demand reaching limits.

18. **Lymphoedema** is a chronic condition affecting approximately 1 in 7 cancer patients, and many others not affected by cancer. There are major workforce challenges for lymphoedema staff within GM immediately and in the coming two to three years. The current lymphoedema workforce consists of 7.55WTE Specialists, 9.9WTE keyworkers and 2.3WTE assistant practitioners, a total of 19.8WTE with a total of 29 people. There is 1.49WTE dedicated administration support within 4 services.

    Commissioning guidelines illustrate a variation in the understood prevalence. Based on the guidance there is likely to be between 11,131 to 18,126 lymphoedema patients within GM. A clinical workforce 44.5 – 72.5 WTE is recommended in alignment with the prevalence. Within Greater Manchester 3.3WTE specialists and 1.3WTE keyworkers are due to retire in next 6-36 months. There is little evidence of succession planning, and a disparity across the trusts in contract offers to entice staff to retire and return.

    Within GM, Lymphoedema staff often work as loan practitioners with little administrative support, reducing efficiency and clinical face to face time with patients. Annual leave and sickness often causes a complete cessation of service and there is no Bank or Agency Service for cover. Recruitment is difficult due to specialisation. Training is costly, which takes 6-12 months, and is not available within GM. There is no formal mentoring for newly qualified practitioners and specialist staffs are too weighed down to support and mentor staff in training.

19. **Psychological support:** a workforce review of psychological services in GM and EC conducted in 2017 highlighted the need for 37.4WTE clinical psychologists (level 3 / 4) across GM and EC specialising in Psycho-oncology to ensure people affected by cancer have appropriate access to emotional / psychological support, representation at MDTs and to provide ongoing support to level 2 providers such as the CNS. Feedback from the lead cancer nurses is that supervision is variable across the trusts but invaluable for both them and the care they are providing to PAbC.

20. **Specialist palliative care:** It has been evidenced through the Macmillan Specialist Palliative Care Service Test Models and Manchester End of Life Macmillan funded programmes from 2018 to date that there is a shortage of specialist palliative care nursing and senior medical provision. Workforce gap analysis in 2019 conducted through the Strategic Clinical Network suggested that an additional 17 WTE Palliative Medicine Consultants would be required to deliver 7 day services; providing the capacity and flexibility to deliver these services in a collaborative way. However, the expansion of this senior medical led provision is not likely to be achieved in its

entirety, so GM and EC needs to consider a build of multi professional teams in an innovative solution of blended roles and training facilities to tackle the capacity required to deliver the most appropriate care to patients and families at the right time.

Progress to date

21. Histopathology: GM has been working with NHSI to progress the establishment of a GM pathology network. There has been agreement from all providers on a partnership hub and spoke operating model and a proposed offer will be presented to the Provider federation board at the end of November. Establishing a GM pathology network will not only bring financial benefits but ensure a more efficient, equitable service for PAbC, reduction in outsourcing costs and more efficient use of the workforce. From a workforce perspective it will address capacity issues and give the opportunity to explore new roles to support service delivery, career opportunities, personal development and therefore a highly motivated workforce. There are also plans to develop a digital pathology platform similar to the PACs project which again will impact on pathology capacity.

22. Radiology: there has been a lot of good practice in a number a trusts to address the workforce shortages including recruitment drives, career packages to attract more candidates, establishing relations with higher education institutes to offer placements / capitalise on trainees due to graduate, dedicated resource to support practice education / postgraduate training, annualised contracts which allows more flexible working to help with retention, and international recruitment. However, the GM radiology board disbanded and therefore there is currently no forum for sharing best practice.

    GM has benefited from a number of HEE offers to expand the radiology workforce including funding for trainee reporting radiographer posts with 26 posts funded since 2018 and a further 10 in 19/20 (including upskilling radiographers in breast imaging to support breast services). There has also more recently been funding to upskill the sonography workforce, with a total of 13 trainees being funded across GM and EC with further funding opportunities for the endoscopy workforce due to be released.

    International recruitment has been relatively successful across GM as an immediate solution to close the gaps and allow time to upskill the current workforce. This is being led via a number of different routes: individually by trusts with reported varying levels of success; a GM wide international recruitment programme commissioned by the GMHSC partnership and led by the Manchester Foundation Trust (MFT) and a national programme - Global health programme (GHP) led by HEE. To date GM has benefited from 3 clinical radiologists from the GHP, with further opportunities anticipated in 2020.

23. To address shortages due to limiting numbers coming through the pipeline, GM Cancer has championed piloting new roles to support existing staff as part of the accelerated pathway transformation projects, including cancer navigators, and cancer support workers to support implementation of the recovery package. These in the main support the CNS workforce and evidence suggests that these new roles have had a positive impact on patient experience.

24. The GM Cancer Education transformation programme aims to provide equal access and opportunity to education for the cancer care workforce in GM & EC, across health and social care, to ultimately improve patient experience, whilst also promoting and supporting workforce development. The programme conducted an initial scoping exercise looking at training and education needs across the system and as a result of this the following programmes will be commissioned up to the end of March 2021: Communication & Psychological Level 2 training for CNS's and/or equivalent key workers to commence in December; support for MDT Coordinators across GM, which will include training, peer support and a forum for sharing best practice; and a tailored education programme for cancer navigators, funded as part of the GM Cancer accelerated pathway transformation projects (Colorectal, Prostate, Lung), to support them in their role and to ensure consistency in service provision across GM.

25. The Salford specialist palliative care test model has shown positive impact on workforce as a result of embedding a clear career progression framework into band 8a roles. The Band 8a's can support other colleagues as well as providing enhanced care and support to patients and families, and then access senior medical advice and support if needed. This service has gained nominations into the Health Service Journal and Nursing Times award schemes. However, Band 8a provision has led to recruitment issues in fulfilling the vacancies of Band 7's when positions have stepped up.

    The Wigan pilot site has focussed on upskilling band 6's and 7's to support patients and families and then accessing senior medical support as needed. In both Wigan and Salford, the CNS have been supported through prescribing and clinical skills courses to enhance their roles and skills. An innovative academy solution has been proposed suggesting a long term plan of educating nursing professionals from Band 5 up to the next stage of specialist palliative care to address these on-going work force needs. There is an on-going work stream to support the development of senior palliative medics as well.

26. To address gaps in the lymphoedema workforce there is joint meeting with commissioners, managers and service providers in December 2019. The meeting is to look at what changes are needed to reduce the variation of services, improve consistency and equitability of lymphoedema provision across Greater Manchester by agreeing a set of standards. This will address what is the expected workforce, skill mix and required training to align with the agreed standards.

Potential levers

27. In addition to the levers mentioned above (international recruitment, recruitment campaigns, developing career packages, flexible working, sharing best practice, establishing networks) there are a number of other potential levers that could help to address workforce issues.

28. Publication of the NHS People plan has been delayed due to the general election. However, once published in the New Year this will be a significant lever for a number of professions, specifically the nursing workforce, which will be one of the main priorities.

29. With a number of professions having high percentages due to retire in the next 5 years, attractive retire and return offers with flexible working, built in training / education / mentorship roles could be of real benefit to capacity issues and ensure knowledge skills and experience are not lost.

30. Training and development opportunities: GM Cancer has built strong links with HEE to ensure GM can capitalise on future training opportunities such as the endoscopy training course in 2020 and offers to develop the healthcare science workforce.

31. Technology developments: ensuring GM grows a digitally ready workforce. The PACs programme will have a positive impact on the current and future diagnostics workforce and will enable cross site reporting / reporting from home. Similar plans are being explored for a digital pathology platform.

32. Exploring alternative routes into cancer care for healthcare professionals, for example apprenticeships (mammographer, diagnostic and therapeutic radiographer, healthcare science); advance clinical practice; allied health professionals (AHPs).

33. Linking in with national programmes of work: GIRFT who are currently working with GM trusts to address current issues with radiology services including workforce, NHSI pathology networks, CRUK, Macmillan.

34. Clinical mobilisation: 'passport' programmes for the medical and non-medical workforce building on work already done in this area to see if this something GM could introduce for the cancer workforce.

Next steps:

35. It is important to acknowledge the vast array of workforce challenges that need to be addressed for GM, some of which may not have been captured in their entirety in this paper however, the purpose of this paper is to propose areas of priority to focus activity over the next 15 months, for the duration of the cancer workforce lead post. This is led by greatest need i.e. which professions have the biggest workforce gaps, which parts of the workforce are causing delays for PAbC, current opportunities, alignment with national priorities and where we can achieve the biggest impact. The workstreams identified below are not an exhaustive list and it is anticipated that this will evolve over time as opportunities present.

36. Diagnostics will be a key priority area as this is cited as the main factor affecting performance targets and causing the biggest delays for PAbC. Quantitative data provided by trusts supports the need for this to be a priority area, with the biggest gaps being in pathology and radiology.

    The CWL will work with the pathology transformation leads to explore new roles in histopathology as proof of concepts for the workforce transformation that will be required when developing GM pathology networks.

    The clinical leads leading the pathology network will also be overseeing the development of a GM radiology network once confirmation has been received from NHSE.

International recruitment – GM cancer is building links with the national global health programme to explore involvement in the next pilot for international recruitment of radiographers and with the GM international recruitment initiative to avoid any duplication and to maximise benefits for all GM and EC providers. The GHP pilot would include recruiting 15 radiographers (5 therapeutic, 10 general diagnostic including 5 'domino' places to allow upskilling of NHS radiographers to mammographers).

37. Rapid diagnostic centres (RDCs): these have not been discussed in any detail within the paper as plans are still progressing. The CWL will be linked in to this work to support the workforce element and explore piloting new roles.

38. Nursing (CNS): CNS are a critical part of the cancer workforce and an invaluable source of support for PAbC throughout the whole pathway. To ensure alignment with national priorities such as the People Plan, the nursing workforce will be a key focus. Plans are already being discussed with lead cancer nurses, Macmillan and Directors of Nursing to follow work led by the London lead cancer nurses to establish a community of practice as a forum to collaborate, share learning and focus on a small set of actions where they can have maximum impact which could include the following:

    - Supply and retention
    - Succession planning
    - Training and education

39. Addressing shortages in numbers coming through the pipeline through piloting new roles to support the cancer workforce including:

    - Allied Health Professionals: this is the 3rd largest professional workforce in the NHS with 14 disciplines however, the role of AHPs in delivering cancer services is unclear. They play a pivotal role in diagnosis (radiographers), and personalised treatment being a key link between primary and secondary care but yet remain an underutilised part of the cancer workforce in GM. There are a number of case studies from other cancer alliances of AHPs delivering cancer services, for example, Advanced practitioner radiographer running clinics to address consequences of cancer treatment; training to perform US guided drain insertion for ascites (previously done by radiologist) to reduce waiting times; upskilling paramedics in specialist palliative care to reduce emergency admissions. Further work is needed to understand how best GM could tap into this resource. Plans include:
        - Conducting a scoping exercise with AHPs in cancer, similar to what is in progress in other alliances
        - Hosting an AHP education day to look at upskilling opportunities for all AHPs
        - Linking in with the AHP advisory group in GM / regional leads.

    - Physician Associates: GM cancer has received funding to pilot a PA preceptorship in cancer services, which will be piloted in the urology cancer pathway to support the accelerated pathway project.

    - Specialist palliative care: plans to support a workforce task and finish group to look at which new roles could support the current gap in medical professions.

40. Joint working with the GM Cancer Programme Director for performance to help address workforce issues impacting on performance, some of which have been highlighted above.

41. Collaborating with key partners such as CRUK and Macmillan to address key workforce issues for GM and EC, for example by continued horizon scanning for further key service changes and research findings which will impact the cancer workforce.

42. Establishing a workforce steering group to provide governance over the workforce plan deliverables. Membership is currently being considered but will involve representation from each of the key professions in the CWP and representation from each of the provider trusts.

43. This scoping exercise has highlighted the paucity in workforce data, different methods being adopted by the partnership, alliance and HEE and the need to standardise how cancer workforce data is being captured to enable future planning / horizon scanning. The CWL will work with HEE, GM cancer data analysts and workforce leads at the partnership to explore how best to address this

Recommendation

The GM Cancer Board is asked to approve the priorities and approach set out in this paper.

Appendix 3: CNS data across GM presented against NHSE assumed and actual increase in activity. Data compared between August 2018-August 2019.

Pathway	Pennine	MFT (WTWA)	East Cheshire	WWL	Stockport	Bolton	T&G	Salford	GM Total	7% - NHSE activity assumption	% of activity increase for each pathway	Projected numbers needed to meet actual rise in activity**	% increase in 2WW Referrals	Projected numbers needed relating to increase in 2ww referrals
Lung	9.06	9.6	4	2	3	2.6	3	1.5	34.76	37.19	2.0%	35.44	7.04%	37.21
Haemato-onc	4.06	12.4	1.6	na	3	3	2	2	28.06	30.02	3.9%	29.14	16.62%	32.72
Breast	11.12	11.1	3.35	4	NA	5.23	4	no service	38.8	41.52	4.9%	40.71	20.25%	46.66
Colorectal	5	4.8	1	2	3.62	2.6	4	7.05	30.07	32.17	11.1%	33.40	18.84%	35.74
Urology	6.8	8	1.4	3	4	1.6	1.6	3.45	29.85	31.94	15.9%	34.61	6.85%	31.89
Gynaecology	2.67	7.1		1	1	0.8	0.5	1	14.07	15.05	12.3%	15.79	21.04%	17.03
Head & Neck	3	4.4	0	2	1		0.5	1.6	12.5	13.38	11.1%	13.88	19.26%	14.91
Upper GI	1	1.6	1	1.5	1		1	4.8	11.9	12.73	10.0%	13.09	7.23%	12.76
Skin	0	2	NA	1.6	NA	0.64	2	1.73	7.97	8.53	11.4%	8.88	14.62%	9.14

Sarcoma	0	2	0	na	NA	0	0.1	No service	2.1	2.25	-13.6%	1.81	10.50%	2.32
Brain/CNS	0	N/A	0	na	na	0	0.1	0	0.1	0.11	164.0%	0.26	15.23%	0.12
HPB	1	4	inc in upper GI	2	1	0.75	0.8	1	10.55	11.29	8.8%*	11.47	14.30%	12.06
OG	See Upper GI	N/A		na	1		1	see upper GI	2	2.14	10.0%	2.20	7.23%	2.14
acute oncology	5	7.6	1.6	3	1	4.35	1	2.2	25.75	27.55	8.8%*	28.01	14.23%*	29.41
chemotherapy (WTWA)		3.85							3.85	4.12	8.8%*	4.19	14.23%*	4.40
Thoracic hub (WTWA)		10.2							10.2	10.91	8.8%*	11.09	14.23%*	11.65
mesiolioma team (WTWA)		1.6							1.6	1.71	8.8%*	1.74	14.23%*	1.83
Skull base								2	2	2.14	8.8%*	2.18	14.23%*	2.28
Grand total	48.71	90.25	13.95	22.1	19.62	21.57	21.6	28.33	**266.13**	**284.76**	7.36%**	**287.89**	13.47%**	304.927

*where there was no pathway % available the overall average % was used

**this is lower than the true average of 8.8% because the true average included pathways not included in the list above

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number **7**

Greater Manchester Cancer

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	28th November 2019	
Title of paper:	**Greater Manchester Cancer Pathway Board Leadership update**	
Purpose of the paper:	To update the GM Cancer Board following changes surrounding the leadership of the pathway boards	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	☐	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient experience and outcomes **Reducing inequality** **Minimising variation**	The primary responsibility of the pathway boards is to improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire. This approach ensures there is focus on reducing inequality and addressing variation across the system. This update follows the board paper presented in July 19 and details progress of the leadership review of the pathway boards ensuring their effectiveness is maximised.	
Operational / financial efficiency	Making improvements in cancer outcomes will support the delivery of the financial and operational efficiencies described in the GM Cancer Plan.	
Author of paper and contact details	**Name:** Alison Armstrong **Title:** Programme Lead, Greater Manchester Cancer **Email:** alison.armstrong7@nhs.net	

Date: 28th November 2019

Title: Greater Manchester Cancer Pathway Board Leadership update

From: Alison Armstrong, Programme Lead, Greater Manchester Cancer

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1 Background and Context

In July 2019, a paper presented to GM Cancer Board outlined a number of proposed changes to the leadership of the pathway boards in order to ensure that the clinical boards continued to be highly relevant and at the forefront of GM Cancer's enterprise in meeting the current challenges. Following support from the board, the leadership review was progressed.

2 Leadership review

In autumn 2019, an open competitive interview process against peers was undertaken for all roles where the Pathway Director had been in post in excess of 3 years. Nine Clinical Lead positions were advertised and the remaining nine were subject to an annual appraisal. The recruitment began with the GM Clinical Lead for Breast Cancer due to the existing vacancy. The interview panels, chaired by the GM Cancer Director/Associate Medical Director included representation from service users, the GM Cancer senior management team, commissioning, primary care, Provider Federation Board and a Pathway Manager. As part of the selection process, shortlisted candidates were asked to deliver a 10 minute presentation 'Tell us why you are the right person to clinically lead xx cancer across GM in 2019, list the main challenges and also outline what you will deliver within 12 months if appointed'

Following recruitment/appraisal, the table below details the current leadership of the GM Cancer Pathway Boards.

2019 Recruitment	**Post Holder**
Clinical Lead for Breast Cancer	Miss Clare Garnsey
Clinical Lead for Skin Cancer	Vacant
Clinical Lead for Brain & CNS Cancer	Dr Catherine McBain
Clinical Lead for OG Cancer	Mr Javed Sultan
Clinical Lead for Urological Cancers	Mr Satish Madennini
Clinical Lead for Gynaecological Cancers	Vacant
Clinical Lead for Acute Oncology	Dr Claire Mitchell
Clinical Lead for Colorectal Cancer	Mr Sajal Rai
Clinical Lead for Childhood Cancers	Professor Bernadette Brennan

2019 Appraisals	Post Holder
Clinical Lead for Sarcoma	Dr Amit Kumar
Clinical Lead for Head and Neck Cancer	Dr David Thomson
Clinical Lead for Lung Cancer	Dr Matt Evison
Clinical Lead for Haematological Cancers	Dr Eleni Tholouli
Clinical Lead for Genomics	Professor Fiona Blackhall
Clinical Lead for Psychological Support	Padraig McDonnell
Clinical Lead for Hepatobiliary Cancers	Mr Thomas Satyadas
Clinical Lead for Supportive Care	Anne-Marie Raftery
Clinical Lead for Teenage and Young Adult Cancers	David Wright

Please note the existing vacancies in leadership of the gynaecological and skin pathway boards as recruitment of high calibre individuals was unsuccessful. It is planned for these posts to be re-advertised in the next few weeks.

3 Recommendation to Cancer Board

Cancer Board is asked to note the content of this report and provide feedback.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number

8

Greater Manchester Cancer

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	28th November 2019	
Title of paper:	**Greater Manchester Adrenal Cancer Summit**	
Purpose of the paper:	To update the GM Cancer Board on the discussion and agreed next steps following the Greater Manchester Adrenal Cancer Summit held in September 2019.	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	☐	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient experience and outcomes **Reducing inequality** **Minimising variation**	The primary aim of the summit was to understand if a single GM approach for adrenal lesions could be agreed to help improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire. This approach ensures there is focus on reducing inequality and addressing variation across the system.	
Operational / financial efficiency	Making improvements in cancer outcomes will support the delivery of the financial and operational efficiencies described in the GM Cancer Plan.	
Author of paper and contact details	**Name:** Alison Armstrong **Title:** Programme Lead, Greater Manchester Cancer **Email:** alison.armstrong7@nhs.net	

Greater Manchester Cancer Board

Date: 28th November 2019

Title: Greater Manchester Adrenal Cancer Summit

From: Alison Armstrong, Programme Lead, Greater Manchester Cancer

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4 Background and Context

This report follows the Greater Manchester Adrenal Cancer Summit which was held in September 2019. The purpose of the meeting was to bring people together to understand if there was a clinical consensus on possible changes in order to encourage a single GM approach for adrenal lesions. Several clinicians had flagged up a series of incidents/issues and there was a feeling that the GM adrenal cancer group could be a little better connected. The meeting aims included:

- to allow for better development of a GM Clinical Network
- to develop a standardised, single way of working up adrenal lesions
- to prepare for the release of the national specification
- to capture opportunities for adrenal developments
- to help drive research

It was outlined that NHS England are setting out intentions in a national specification in relation to suspected adrenal cancer and how best to manage patients. The draft 2019 NHSE service specification was circulated to attendees in advance of the meeting. It was recognised that liaising closely with commissioners was vital. It was noted that Sheffield have a clear pathway to surgery and a single MDT which had led to the service 'attracting' cases from a wide geographical region.

5 Summary of key discussion points

What are we doing well in GM?	
Discussion summary	The positives of the current GM provision were discussed. The joint decision making process is collegiate as there are a number of MDT's already in place for adrenal patients (MRI, Salford, Stockport and UHSM) There is an established MDT proforma and guidelines in place with regular audits of the already MDT's underway. Oncology and pathology expertise were noted as strengths of the current service with adrenal lesions being correctly diagnosing with pathology. A new standard way of reporting adrenal lesions is being developed Biochemistry works well and there are strong academic links with Sheffield and Birmingham. International links are well established also.

	There is already a recognised network with network with good connections between endocrinology, surgery, radiology and biochemistry Some joint clinics are occurring for difficult cases A better understanding is needed of how GM would evidence a robust, expert service model being delivered on more than one site? This differs from the model in Birmingham and Sheffield who deliver their service using one centre.

What are the challenges of the adrenal pathway in GM?	
Discussion summary	The delivery of the 62 day pathway was seen as the biggest challenge when such a small number of adrenal lesions are cancerous. There was discussion regarding which patients go onto the 62 day pathway. There is a need and desire to retain a GM adrenal service and debate followed on how we could standardise the process without unpicking the good work already happening. Consideration needs to be given to learning from the work around thyroid. For some cases, a specialist forum is needed however we don't know which cases these are To assist in strengthening the GM adrenal network, is there a value in the adrenal community meeting on an annual basis? This would allow the communication of audit outcomes etc. and would be well received externally as demonstrates system learning.

What is the work up of adrenal lesions?	
Discussion summary	The question was posed of 'can we describe the diagnostic work up of patients with adrenal lesions and are cases discussed weekly, bi-weekly, monthly currently'? Discussion took place regarding whether it was appropriate to use ENSAT criteria and if this could merely be refined to document the 'GM way' of doing things There seems to be variation from centre to centre regarding biochemistry but it was recognised that a consensus was needed to remove this variation. One example of the variation was given in that urinary steroids are being introduced at MFT around Christmas time. It was acknowledged that as regards radiology, the key here was to have all the imaging available but that GM PACS will help support this however this will only be rolled out at the end of 2020. Standardised reporting would also be helpful

Which patients would be referred to a GM adrenal cancer sMDT?	
Discussion summary	A standardised data set referral would be invaluable to assist with the decision making process of which patients would be referred to a GM adrenal cancer sMDT? The European guidelines include: • Multiple hormone secretors • Radiological signs (perhaps including growth, PET positive) • Larger than 4 or 6cms (there were differing opinions in the group) • local invasion Consideration also needs to be given to including interesting, concerning cases or those with clinical ambiguity where advice is required Agreement was reached to develop a task and finish group to create guidelines starting with the ENSAT guidelines as a starting point and then finesse. This would allow the 'filtering' of potential patients.

6 Next steps

Agreement was reached that there was a need for a GM standard for adrenal lesions, GM audit, a supported GM adrenal community and a GM learning forum. Following the constructive discussions, there were some key actions identified which include:

- **Develop a GM approach to work up of adrenal lesions** - (based initially on the ENSAT standards), using a common biochemical, radiological and endocrinology approach across the 4 main hubs (Salford, UHSM + MRI, Stockport)

- **Develop a protocol for patient selection for the GM-level Adrenal SMDT** - based initially on ENSAT standards), and offer proposals on how such a regional SMDT might work.

- **Liaise with Commissioner** – The specialised commissioning team to be informed of the summit discussions and appropriate links made between spec comm. and GM Cancer regarding the new specification once this is produced and released. In addition CCG commissioners to be made aware of the adrenal pathway discussions for assurance re the future national spec, but also to ensure their involvement in future discussions where required for local service commissioning.

The offer of GM Cancer facilitating meetings and consolidating the GM adrenal community was made.

7 Recommendation to Cancer Board

GM Cancer Board is asked to note the content of this report, provide feedback and support the next steps identified above.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number 9

Greater Manchester Cancer

Communications Update

This report covers national and regional updates within cancer, including announcements on systems, resources, research, political changes and cancer in the media.

National updates

- **Sir Mike Richard's Screening Report (published Oct 2019)**

Sir Mike Richards has published his report of *The Independent Review of Adult* Screening Programmes in England, published on the NHS website.

Many news outlets focused on recommendations to make screening fit in with people's increasingly busy lifestyles, by allowing screening appointments to be made on weekends and during lunch breaks. Other recommendations in the review included reuniting responsibility for screening programmes in England under a single organisation and improving IT to reduce screening errors.

To view the full report, visit: https://www.england.nhs.uk/publication/terms-of-reference-review-national-cancer-screening-programmes-england/

- **New guidance for Multi-Disciplinary Team Meetings (MDTM) – update**

The Independent Cancer Taskforce Report published in 2015 recommended that NHS England should encourage providers to focus specialist time in the MDT meeting on those cases which do not follow well-established clinical pathways.

The NHS Cancer Programme has produced new guidance, soon to be published, on how MDTMs can streamline to focus time on more complex cases through the introduction of *Standards of Care* (SoCs). A *Standard of Care* is a point in the pathway of patient management where there is a recognised intervention (or interventions) that should be made available to a patient. The MDTM will maintain oversight of all patient cases, but where a patient's need is met by a *Standard of Care* the case would be listed but not discussed at the full MDT meeting.

Providers and Alliances will already have predetermined SoCs in place for the diagnosis and treatment of (suspected) cancer patients. For the purposes of MDTM streamlining, these agreed standards must be formalised and strengthened to identify which patients do not require discussion at the MDTM.

The approach aims to improve clinical management for all patients referred to the MDTM by improving consistency and transparency of pathways, creating adequate time for discussion of patient cases where it is required, and ensuring the best use of clinical and diagnostic time. *Standard of Care* pathways will be applied in the wider context of personalised care, and clinical teams will always ensure that, when planning treatment for any patient, their individual circumstances and wishes are always paramount.

The MDT streamlining guidance will not be a one-size-fits-all approach. However, where clinically appropriate it is envisaged to be a useful tool to support pathway improvement for patients and optimise use of clinical time.

An update will be given when the full guidance is finalised and published. Colleagues are thanked for avoiding wider circulation outside of the Cancer Alliance until final details are confirmed.

- **Health Education England Phase 2 Cancer Workforce Plan - Update**

The Phase 2 Cancer Workforce Plan was written in 2018 as pledged however, publication was delayed due to publication of the Long Term Plan and interim people plan. The plan is now out of date, but many of the questions it raises about long term demand and supply and the impact of digital technologies are still relevant; HEE has therefore published an update which can be accessed here: https://www.hee.nhs.uk/our-work/cancer-workforce-plan

- **Pre-election purdah period (effective from 6 Nov 2019)**

With a General Election announced for 12 December 2019, Parliament dissolved earlier this month, with the pre-election purdah period beginning on Wednesday 6 November 2019.

For additional NHS guidance on purdah, please see the following link: https://nhsproviders.org/resource-library/briefings/2019-general-election-pre-election-period-considerations-for-nhs-foundation-trusts-and-trusts

- **29 charities collaborate in 'One Cancer Voice' manifesto, calling Government to take action**

The manifesto, led by Cancer Research UK, recommends 6 key points to Government to consider to improve cancer care and survival chances which it highlights are "not exhaustive". These are:

1. Put the right staff in place
2. Diagnose cancer earlier
3. Ensure people living with cancer have access to the appropriate treatment and psychological support
4. Support people living with cancer beyond their treatment
5. Preserve the UK's status as a world-leader in cancer research
6. Prevent people from developing cancer

Within each of these points, the manifesto makes a number of clear recommendations to Government, including implementation of Sir Mike Richards' screening recommendations, delivery of stratified follow-up pathways, retaining UK status as a world-leader in research and sustainably fund local stop-smoking services.

The full manifesto is available to read via the following link, and the campaign is live on social media via the hashtag #OneCancerVoice:
https://www.cancerresearchuk.org/sites/default/files/one_cancer_voice_-_final_1.0.pdf

- **Cervical screening: DIY alternative to smear test 'promising' (BBC, 5 Nov 2019)**

A new 'DIY' urine or swab test that can be done at home could provide an alternative to current cervical screening tests, reports the BBC. Scientists at Queen Mary University of London asked 600 women to provide self-collected samples for screening. The findings, being presented at the NCRI cancer conference in Glasgow, suggest the method is feasible and popular. So far, only people with advanced cervical cell changes that were picked up through existing screening tests have been studied. Researchers will now need to test how effective the kits are for more people, including those who've had normal screening results before.

- **New breast cancer drug made available on the NHS in England**

The National Institute for Health and Care Excellence (NICE) has approved the use of a targeted drug, neratinib (Nerlynx), for some people with early breast cancer on the NHS in England. Cancer Research UK has produced a useful report about the approval, who it's for and potential side effects: https://www.cancerresearchuk.org/about-us/cancer-news/news-report/2019-10-17-targeted-breast-cancer-treatment-approved-for-nhs-use-in-england

- **Raconteur Combating Cancer Publication (published Oct 2019)**

Raconteur's recent publication features a number of brief references to Manchester services and clinicians, including a section on CAR-T therapy (p.4), RDCs (p.5) and the use of art and play therapy at The Christie Proton Beam Centre (p.6).

The report also features a full feature on The Christie's Proton Beam Therapy Service: "Cutting risk for life-saving treatment" (p15).

To view the full report, visit https://www.raconteur.net/combating-cancer-2019

Regional Updates

- **HEE funding – Workforce transformation project update**

We have recently received from HEE for a workforce transformation project. GM Cancer is using this funding to develop a physician associate preceptorship programme in cancer services. This will be piloted in the urology cancer pathway with physician associates working across boundaries in both primary and secondary care, and will be a proof of concept for the upcoming Rapid Diagnostic Centres. We hope to start the pilot in early 2020 which will also support the delivery of the prostate cancer accelerated pathway project.

- **Rapid Diagnostic Centres update**

In line with NHSE policy, published in July 2019, GM Cancer Alliance is leading on the development of RDCs across Greater Manchester. This 5 year national programme aims to contribute to the following objectives:

- Earlier and faster cancer diagnosis.
- More efficient diagnostic pathways.
- Better personalised diagnostic experiences.
- Reduced unwarranted variation in diagnostic testing.
- Improve the offer to staff.

With the aim of offering:

- A **single point of access** to a diagnostic pathway for patients with symptoms that could indicate cancer – Yes/ No to cancer.
- A **personalised, accurate and rapid diagnosis** of patients' symptoms by integrating existing diagnostic provision and networked clinical expertise.

GM Cancer Alliance is working with the 2 organisations and relevant localities, who over the last 3 years have piloted the MDC approach, through the ACE 2 programme; to move from an MDC to a Rapid Diagnostic Centre (RDC) approach. The Greater Manchester Cancer Alliance RDC programme will include the further geographical development of non- site specific pathways and agreed site specific pathways.

The 2 organisations and associated localities involved in the first phase (19/20) of RDC planning are the Northern Care Alliance and Manchester Foundation Trust. The evaluation of this first phase aims to identify the most appropriate RDC model for whole of GM, establishing:

- Is the RDC a concept a rapid diagnostic service or physical centre or both?
- Are some services (e.g. breast) already offering a Rapid Diagnostic Service?
- Which patients should be seen in the RDC and by whom?
- Do all patients want to be assessed in an RDC?
- What symptoms to include and modes of triage?
- What tests will be carried out in an RDC and prior to referral?
- The type of workforce required to run an RDC.
- Diagnostic capacity.

The Norther Care Alliance (NCA) and Manchester Foundation Trust (MFT) are taking slightly different approaches to the planning of this first phase of RDC implementation, however both aim to go live with an RDC approach from early 2020, as per national guidance. RDCs will be provided on a number of geographical sites within the 2 organisations and aim to cover the populations of Manchester, Salford, Oldham, Bury and Heywood Middleton and Rochdale CCGs.

As per national guidance both organisations will provide an RDC for those patients suspected of having cancer who have non- site specific (vague) symptoms and for phase 1 of implementation have also chosen a number of site specific pathways including: for NCA the gynaecology cancer pathway and for MFT they are proposing to focus on the lung, sarcoma, haematology, gynaecology and HPB pathways. The GMCA RDC Programme Board, which will meet for the first time on the 25th of November will provide assurance to the Greater Manchester Cancer Board on both organisations phase 1 plans.

NHSE is due to publish the 5 year vision for RDCs during November 2019 and GMCA will develop the cancer alliances 5 year plans which will be submitted to NHSE by the end of January 2020.

The GMCA RDC programme and clinical lead will present a further update to the GMCB in January 2020.

- **ACED Grant Announcement - Multimillion pound boost for Manchester scientists to detect cancer earlier (21 Oct 2019)**

Cancer Research UK will invest up to £40 million over the next five years into the International Alliance for Cancer Early Detection (ACED).

ACED is a partnership between Cancer Research UK, Canary Center at Stanford University, the University of Cambridge, OHSU Knight Cancer Institute, UCL and The University of Manchester. Contributions from the Alliance's US partners will take potential investment to more than £55 million.

By combining the power of leading research institutions in the world if early detection, ACED will accelerate breakthroughs, leading to quicker benefits for patients. In Manchester the funding will support scientists and doctors to take forward new cancer screening projects.

Researchers will continue to develop a range of ongoing community early detection projects – from lung health checks in car parks, to urine sample testing for gynaecological cancers.

Read more: https://www.manchester.ac.uk/discover/news/multimillion-pound-boost-for-manchester-scientists-to-detect-cancer-earlier/

BBC North West Tonight *covered this story on 21.10.19:*

This news piece was about the importance of early cancer diagnosis, focusing on a grant that had been announced by Cancer Research UK. The package included an interview with Felicity Algate, director, Behavioural Insights Team North, about action being taken to encourage more Greater Manchester GPs to refer patients when appropriate – mentioned the development of online training package for GPs (GatewayC). Also featured an interview with a woman who had benefited from early detection of her breast cancer through the screening programmes.

- **RadNet Grant Announcement - Manchester scientists lead the way in next generation radiotherapy research (4 Nov 2019)**

Cancer Research UK is investing a total of £56 million in Cancer Research UK RadNet – the charity's largest ever investment in radiotherapy research.

In collaboration with The Christie, the funding will support University of Manchester researchers to use advanced radiotherapy technologies such as proton beam therapy, MR-Linac machines which combine an MRI scanner with a radiotherapy machine to make treatment more precise, and FLASH radiotherapy delivering ultrahigh radiation doses in fractions of a second.

Read more here: https://www.manchester.ac.uk/discover/news/manchester-scientists-lead-the-way-in-next-generation-radiotherapy-research/

- **BBC Radio 5 Live cancer podcast *You, Me and Big C* in Manchester**

The Greater Manchester Cancer team have been working with the producers of BBC Radio 5 Live's award-winning cancer podcast *You, Me and the Big C.* Presenters discuss topical themes within cancer care and the podcast boasts thousands of listeners and has previously been number 1 in the iTunes podcast chart.

Local GP Rebecca Leon is now the podcast's resident GP and has featured on episodes on primary care and second opinions. The team will also be recording special edition on Proton Beam Therapy at The Christie on 18 November 2019.

For further information on any of the above, please contact ***Anna Perkins, Communications and Engagement Lead at Greater Manchester Cancer*** *on anna.perkins@christie.nhs.uk*

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number

10

Greater Manchester **Cancer**

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	28th November 2019	
Title of paper:	**GM Cancer led Transformation Projects Update**	
Purpose of the paper:	The purpose of the paper is to provide members of the GM Cancer Board with an update on progress and highlight risks associated with delivery of the GM Cancer led Transformation Funded projects.	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	✓	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient experience and outcomes	All transformation projects aim to improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire. There are outcomes measures to capture benefits, associated with each project. Due consideration has been given to minimising variation and reducing inequality through the equality impact assessment associated with each project.	
Reducing inequality		
Minimising variation		
Operational / financial efficiency	Making improvements in cancer outcomes will support the delivery of the financial and operational efficiencies described in the GM Cancer Plan.	
Author of paper and contact details	**Name:** Alison Armstrong **Title:** Programme Lead, Greater Manchester Cancer **Email:** **alison.armstrong7@nhs.net**	

GM Cancer led Transformation Projects Update
November 2019

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

Summary of project

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

Progress and Roll Out Proposals

- Work ongoing with the CIS team to identify baseline information to support metric measurement within tableau, anticipating information will be available for the BTP w/c 25th November 2019; Further information sharing will be part of the diagnostic sub group meeting, mid December 2019.
- A well-attended and productive BTP lung / diagnostic sub group was held on the 23rd September 2019.
- Multi-disciplinary work undertaken to scope out a lung cancer service specification for GM
- Ongoing work to develop a diagnostic subcommittee work plan and high level milestones for the lung pathway board.
- The implementation and recruitment process has commenced, with the following progress to date:

Salford NHS FT	Pathway Navigator Recruited October 2019
Bolton NHS FT	Pathway Navigator Recruited November 2019 CNS not appointed, out to re advert November 2019
WWL NHS FT	Pathway Navigator Post currently out to advert
Pennine NHS Trust	One CNS Recruited October 2019 Further 3 posts not recruited to; out to re advert
MFT (Central)	ST6 Fellow Recruited September 2019 Pathway Navigator Recruited November 2019
T&GC NHS FT	Pathway Navigator Recruited October 2019 CNS Post at advert stage
Stockport NHS FT	Pathway Navigator Recruited November 2019 CNS Post shortlisted, Interviews Mid November 2019
MFT (Wythenshawe)	CNS Recruited November 2019

Mid Cheshire NHS FT	Pathway Navigator Band 4 Recruited November 2019 Pathway Navigator Band 5 Post at Advert Stage Pathway Navigator Post out to advert November 2019 CNS Post Out to advert November 2019 Equipment purchased November 2019
The Christie NHS FT	Pathway Navigator Recruited July 2019 SABR Technician Not advertised currently Dosimetrist not advertised currently

Measures of Success

- To agree and implement new pathways that ensure our patients begin their treatment within the current standard of 62 days
- Through a stepped approach increase the proportion of patients given definitive cancer diagnosis, or all clear within 28 days of referral by a GP to 95% by 2020
- Referral to treatment reduced to 28 days by 2021
- Ensure that dedicated patient feedback and surveys support pathway design and patient satisfaction

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

Summary of Project

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

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

Progress and Roll Out Proposals

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

Progress to date includes:

- Workforce proposals for all Trusts in GM approved and recruitment has begun locally, with the first prostate pathway navigator in post at SRFT. Beginning by reviewing referral process into Trust/and supporting documentation to navigate the first patients formally along the pathway

- Central training for pathway navigators being considered for Feb/Mar 2020 to support induction/ongoing networking and support for those new in post

- Standardised mpMRI scan protocol agreed across GM (and E Cheshire/Mid Cheshire Trusts also as their prostate services align with GM).

- Discussions with Radiology departments and trajectory for the straight to test mpMRI scan to be offered pre-biopsy across all of GM by 1/4/2020. By end q3 (Dec 19), 5/7 GM Trusts will be offering pre-biopsy mpMRI to MR suitable patients.

- The Equality Impact Assessment is in draft and submitted for comment

- 4th steering group meeting date 26/11/19

- Data - Trust monthly report in draft format (to be used to monitor progress against outcomes)

- Data – NHSI pathway analyser toolkit to be piloted to navigate patients against key dates in draft (via Cancer Managers)

- Data – under review as to which specific metrics that can be collected centrally for the suspected prostate cancer referrals (rather than by the individual Trusts' pathway navigators/local Trust systems)

- Draft patient information sheet is with the Prostate Small Community for comment (service users)

- Draft patient experience survey is with the Prostate Small Community for comment (service users)

- Discussion ongoing regarding GM-wide move to transperineal (TP) prostate biopsies under local anaesthetic and what would be necessary for this to be implemented with equal access for the GM population, with consideration to TP equipment funding within the prostate best timed pathway budget

- Continuing engagement with stakeholders

Measures of Success

The key measures of success are:

- Compliance with the Faster Diagnosis Standard (28d) by end March 2020 (NHSE threshold to be confirmed)
- More than 90% of suspected prostate cancer patients rating their diagnostic pathway as very good by end March 2021 (scale for patient experience survey to be confirmed)
- More than 90% of suspected prostate cancer patients rating their diagnostic pathway as good/very good/excellent by end March 2021 (scale for patient experience survey to be confirmed)
- 25% relative reduction in the number of prostate patients having biopsies by end March

2021

- More than 90% of patients with prostate cancer confirmed by biopsy to be discussed in specialised MDT by day 21 by end March 2021.

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

Summary of Project

Colorectal cancer is the fourth most common cancer and the cancer that takes the second highest numbers of lives every year in the UK. Greater Manchester is currently facing challenges with the delivery of the cancer waiting time standard for colorectal cancer, with 67.5% of patients receiving their treatment within 62 days for 2018/19. (National standard 85%). Furthermore, by 2020 the new Faster Diagnosis Standard (FDS) of confirmation of cancer diagnosis (or no cancer) by day 28 following a suspected cancer referral will be implemented. The NHS planning guidance for 2019-20 includes the following statement:

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

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

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

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

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

Progress and Roll Out Proposals

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

projects can be measured as the project is rolled out across GM.

The project is currently in the recruitment stage for the new CNS and Pathway Navigator roles. Half of all new roles funded by the project have now been appointed. The table below shows the current recruitment progress as of 12th Nov. 2019.

Trust	Roles out to advert	CNS recruited	Pathway Navigator recruited
Bolton			
MFT (MRI)			
MFT (Wythenshawe)			
Pennine			
Salford			
Stockport			
Tameside & Glossop			
WWL			

All Trusts are currently creating SOPs and putting the due processes in place in preparation for the new STT pathway, which is being supported by the Steering Group and project team. The first Trusts to launch the new service will be doing so in December 2019, with all Trusts due to have the new service operational in the New Year.

Measures of Success

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

The GM-wide outcome measures are subject to change due to the national FDS target for 28 day not yet being confirmed. The key outcome measures are as follows:

1) Achieve Faster Diagnosis Standard (28d) by March 2020 including associated outcomes detailed within the project outcomes framework.

2) Reduce to <50% the percentage of patients who require an OPA before endoscopy, releasing OPA capacity

3) Reduce the number of DNAs and cancellations for first investigation by 30%

4) Decrease by 30% the number of occasions that secondary care needs to contact primary care in relation to an urgent colorectal cancer referral i.e. needing more information that was not included in the original referral.

5) More than 90% of suspected colorectal cancer patients rating their diagnostic pathway as good/very good/excellent by end March 2021 (scale for patient experience survey to be confirmed)

If this project succeeds we would expect:

Patients: To receive faster diagnosis; improved associated outcomes; less unnecessary outpatient appointments and report higher comparative levels of patient satisfaction on the new pathways

Secondary care health professionals: To see improved outcomes for patients; report their own time being used more efficiently and effectively; in some cases have tasks being taken off their hands to enable more direct contact with patients; to be positively impacted by the resource savings associated with decreasing the number of outpatient appointments

Primary care health professionals: To see improved outcomes for patients; to feel more confident about their urgent referral process for colorectal cancer; to have a stronger relationship with secondary care in relation to their colorectal pathway

Commissioners: To observe improved outcomes for patients; to feel confident of their locality meeting the 28 day standard from April 2020; to observe improvements in the 62 day standard

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

Summary of Project

Prehab4Cancer is an evidence-based prehabilitation and rehabilitation programme which incorporates exercise, nutrition and wellbeing interventions to optimise people diagnosed with cancer prior to treatment (surgery, chemotherapy and/or radiotherapy) and to support enhanced recovery. This builds on the success of ERAS+ (Enhanced Recovery After Surgery+), the in-hospital offer to surgical patients across Greater Manchester. Approximately 2000 people will benefit from participating in this programme over the next 2 years and it is the first prehab programme to be delivered at scale nationally.

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

The programme is designed to achieve improved clinical outcomes with increased survival rates and improved morbidity. It contributes to greater quality of life, empowering participants to live well with and beyond cancer. Physiological status, PROMs and PREMs are recorded at regular intervals via leisure facilities database system Refer-all. There is provision within this project to develop a digital platform in conjunction with HInM to further support physiological and QOL

data collection, facilitate clinical monitoring of patients and provide enriched participation to the programme. This will include participants using wearable devices (heart rate monitors).

Progress and Roll Out Proposals

Phase 1:

Progress: This programme launched on the 25th April 2019 and has received over 500 referrals within the first 6 months. Over 400 people have now engaged in the programme and are benefitting from increased fitness, strength, nutrition and mental wellbeing through their cancer treatment with improved recovery. 100% of participants are accessing the programme at a leisure facility local to their residential address. Participants are improving by 64 metres* on their fitness assessments during their prehabilitation phase. (*Mean average of all 3 cohorts (Colorectal, Lung and Oesphago-Gastric) on the 6 Minute Walk Test (6MWT) from their initial assessment at the beginning of their prehab phase to their pre-op assessment at the end of their prehab phase. Above 20 metres change on a 6MWT has shown to be statistically significant and goes beyond a 'learnt' affect.)

Roll out has been successfully delivered through stakeholder engagement via the relevant tumour specific pathway boards (Colorectal, Lung and Oesphago-Gastric) with ongoing monthly pathway-specific subgroup meetings to support safe and effective delivery of the programme for patients.

The service specification has a high degree of acceptability from patients referred with an 80% uptake rate from referral and a 93% uptake rate from first appointment. 96% of patients referred are contacted within 2 working days of referral receipt. For those who have not been able to engage this is less to do with issues around acceptance of the offer or motivation to participate. Instead these participants have either had their surgery dates brought forward or we have been unable to contact them due to not having sufficient contact details. The Prehab4Cancer project team is working with key referring clinical teams via the project pathway subgroups (see above description) to rectify referrals issues where possible, in particular addressing some misconceptions a small number of referrers have had about who to refer and when, to maximise engagement access in the programme for all eligible patients.

Patient Experience: Two 'taking stock' participant focus groups have been held in October 2019 (Salford & Harper Hey). These were attended by patients who are now in their rehab phase of the programme, having completed their prehab phase and surgery within the first 6 months of service delivery. Patient experience feedback gained from these groups was overwhelming positive, with all attendees reporting the physical and mental wellbeing benefits they experienced from engaging in the programme. Example comments from these groups include:

"When I've been feeling really low I can concentrate on my wellbeing at the gym – made me feel better about myself"

"I was better able to cope with cancer and the treatment"

"Prehab helped me to leave hospital early"

Further participant focus groups in other localities of GM are planned for the beginning of 2020. In addition a qualitative evaluation will be completed in collaboration with the University of Manchester aimed at people who have not engaged in the programme to support understanding regarding equitable access to the service for all eligible cancer patients. This will take place in 2020 with findings to be included in overall evaluation of the project with key recommendations

to be included in the project's business case.

Education: The Prehab4Cancer 'Fitness for Cancer Treatment: Fitness for Life' education day was attended by 200 delegates (including MDT healthcare professionals, researchers, leisure industry professionals and people affected by cancer) on 11th September 2019. The content of this event aimed to improve the understanding of prehabilitation and rehabilitation principles and guidance enabling delegates to confidently and consistently advise, assess and appropriately treat people affected by cancer. The majority of delegates completed positive evaluation forms following this day and 90% of respondents indicated they planned to change their clinical practice following attendance.

Phase 2:

Eligibility Criteria: Over the last 3 months (Sept, Oct & Nov) the project team have been engaging with key stakeholders from existing eligible clinical pathways and the Head and Neck (H&N) pathway to plan extending eligibility to include patients on non-surgical pathways and appropriate H&N surgical patients. Discussions with these groups have suggested research methodologies will need to be applied to extend programme eligibility criteria and ensure safe engagement in the programme for patient groups in question. As a result phase 2 of programme roll out will aim to launch at the beginning of 2020 once research proposals and ethics have been agreed, in collaboration with key clinical referrers from identified pathways.

High Risk patients: Phase 2 will also include an alternative 'specialist' offer aimed at eligible patients who are identified as high risk with complex co-morbidities, who are currently not able to safely engage in the programme in its current format (delivered by GM Active instructors within community, non-clinical settings). This specialist offer proposes to be delivered in clinical settings, with a mixture of AHP and fitness instructor assessment and treatment, for a small number of patients. This is a key component for overall evaluation of this transformation funded project, particularly designing a multi-faceted service which all patients can access safely.

Nutrition and Wellbeing: The 'Nutrition' expert subgroup has met several times to review nutritional screening used within the programme and potential nutritional interventions which could be included for identified patients. This will be a component of phase 2 implementation. Similarly the 'Wellbeing' expert subgroup continue to support the GM Active team through reflective sessions and further CPD. Stronger links have been made with Macmillan Information and Support Services from across the region, primarily to meet any unmet needs as participants are discharged from the programme.

Digital: HInM has supported the project from a digital perspective and have procured heart rate monitors (MyZone) to be used within the 'universal' and 'targeted' GM Active delivered components of the project. This will support quality assurance of the exercise participants are engaging in, improved patient experience and enhanced evaluation of interventions within the programme. Further support from HInM includes connecting the Prehab4Cancer Refer-All GM Active database with clinical data sets (HES and PQIP) via Tableau, with necessary data sharing agreements in place, for comprehensive evaluation of the project.

Communications and Engagement: A Project Support Officer (B5 0.6WTE) will start in post on 2nd December 2019. They will primarily focus on the development of further patient and clinical information resources to be made widely available including the Prehab4Cancer website, leaflets and posters. They will also support ongoing project stakeholder engagement and communications, alongside the Project Lead and the GM Cancer Comms and Engagement Lead.

Roll Out:

The Prehab4Cancer project team have continued to respond to local and national interest in the programme delivery through visits from other national teams, talks at local & national events and particularly presentations at key GM groups including the recent Directors of Public Health board on Friday 1st November. Prehab4Cancer will be showcase via a poster and breakout session at the GM cancer conference. It will also be a focus at the 2019 annual Greater Sports awards, as an exemplar programme co-designed and co-delivered by GM Active and the NHS in GM via GM Cancer.

Finally a further transformation funding proposal has been submitted to GM Cancer board via GM Cancer SMT to extend the prehab/rehab service model to include other patient cohorts where clinically indicated. The aims of this extension would be to transform the clinical treatment pathways for identified cohorts to include Prehab4Cancer and recovery, adopting the same successful approach to stakeholder engagement, development and delivery as within the current project.

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

Summary of Project

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

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

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

Progress and Roll Out Proposals

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

The chosen sites are Tameside & Glossop and Stockport (joint approach), and The Christie (including Salford and Wigan satellite sites). Recruitment of Cancer Support Workers is now complete, with 5.8WTE staff in post across Stockport and Tameside (of which 5.6WTE funded

by GM Cancer), and 5.0WTE staff commencing in post across The Christie sites between 18th November and 9th December 2019. Note that this is greater than the planned 10WTE, because Stockport and Tameside were able to make their allocated funding of £250k stretch slightly further.

A comprehensive training programme has been agreed for these staff and is being delivered on a rolling basis as individuals come into post. Metrics have been agreed in draft form and will be in place before the end of 2019.

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

Measures of Success

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

- HNAs should be completed around the time of diagnosis and again at the end of treatment (unless declined)
- End of treatment summaries should be provided at the end of every treatment modality
- Access to a Health and Wellbeing Event (or equivalent information and support) should be offered

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

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

Summary of Project

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

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

Progress and Roll Out Proposals

The long term plan is the roll out of CURE to all hospital sites across Greater Manchester. The scope of the phase 1 Transformation Funding bid includes the costs for Wave 1 rollout of CURE to 6 hospital sites (in addition to South Manchester as the pilot site):

- Tameside & Glossop (Tameside & Glossop NHS ICFT – Tameside Hospital site)
- Bury (Fairfield Hospital, Pennine Acute Trust – Bury CCG and HMR CCG)
- Salford (Salford Royal NHS Foundation Trust)
- Oldham (Royal Oldham Hospital, Pennine Acute Trust)
- Stockport (Stepping Hill Hospital, Stockport NHS Foundation Trust)
- Wigan (Royal Albert Edward Infirmary, Wrightington, Wigan & Leigh NHS Foundation Trust)

The GMC CURE Steering Group met again in October and discussed updates for each locality to determine how much progression has been made since the last steering group which has been significant.

Each locality will be asked to present their **CURE model proposal**, using the GM CURE Service Specification to ensure they are delivering against a GM agreed pathway and objectives. These proposals are in the process of being completed by each T&F groups ensuring input from across the locality.

Locality CURE Proposal - GMrollout -

Progress includes:

Pathway mapping & gap analysis sessions have been completed to identify how each locality will deliver the pathway aligning to the GMC CURE Service Specification which is now to be signed out through the locality proposal on how each site will deliver the CURE Pathway, this document will embed all elements of the pathway and describe how, who, where and when the individual elements of the pathway will be delivered.

The CURE Research Assistant work is now underway which commenced in the middle of September. Meetings have already taken place in discussing the best ways to retrieve baseline data for the audits required for this role and a methodology and evaluation framework has been circulated to colleagues involved.

Following the circulation of the CURE proposal document, two providers which are involved in Wave one of the CURE rollout were in a position to present proposals to the steering group. These two sites were the Royal Oldham Hospital and Stockport NHS Foundation Trust. These two proposals were well received by colleagues attending the steering group and were approved for the funding that was allocated in the initial stage by GMC to allow progression with recruitment.

The steering group also discussed a variety of risks that the programme currently has. The following risks are those which the group felt needed to be flagged with a plan to tackle the risks ASAP:

- Wigan engagement from Public Health and progression with mobilisation due to limited availability of clinical lead and lack of Executive support of project – contact has been made with Chief Executive who is keen to implement CURE at Wigan and an extra-ordinary meeting with top level representation from across locality being organised for early December to agree next steps
- Tameside progressing slowly with key decisions due to lack of Executive engagement and clinical leadership – Dr Evison contacted Tameside's Medical Director to request he present at the next Grand Rounds to target clinicians and explain importance of clinical leadership to the success of the CURE project

Upcoming Visits
Derby & Burton Lung Cancer Team – visited Wythenshawe Hospital to see CURE in action
Humber Teaching Hospital – teleconference including presentation of CURE with representation across Provider and Public
Belfast – presenting to the Chief Executive, Director of Hospital Services and Medical Director for South Eastern Trusts about CURE at the request of the lead Smoking Cessation Nurses across NI
Edinburgh – presenting about CURE and how we implemented it at the 'Treating Tobacco

Dependence in hospitals - Seize the Quit' Conference'.

Measures of Success

Please see below a **Data Requirements Schedules and GM Service Specification** which includes Key Performance indicators, and the data that will need to be shared between Provider and CCG to allow service evaluation:


Service Specification - CURE (generic) - ver


SCHEDULE 6_GM CURE - reporting and

These have been shared with Tobacco Commissioners and Cancer Commissioners across all the localities to enable each locality to develop their own contract variation based on these documents to enable transfer of funding for the implementation of CURE as well as detail what data needs to be shared.

PHE Behavioural Insights team have published an ITT for evaluation focusing on 'The Understanding the successful implementation of a stop smoking model in England: An invitation to tender for the development of a behavioural diagnosis'. The CURE Project Team will work with PHE and the successful applicant for this evaluation work.

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

Summary of Project

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

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

- **Bolton NHS Foundation Trust**
- **Tameside and Glossop Integrated Care Foundation Trust**
- **Wrightington, Wigan and Leigh NHS Foundation Trust**

To ensure standardisation of care and an equitable offer to all breast cancer patients in GM.

In addition testing and evaluating a personalised stratified follow-up pathway for colorectal cancer by:

- Testing the agreed schedule of aftercare tests (recently ratified by the GM Cancer Colorectal Pathway Board) at Stockport NHS Foundation Trust and;
- Supporting Salford Royal NHS Foundation Trust to evaluate their long-stranding personalised stratified follow-up service for colorectal cancer patients which will result in an Implementation Toolkit for the remaining GM sites to use when implementing this pathway.

The resources available through the current project funding are:

- An IT solution for tracking stratified follow-up patients with funding to support in-house IT teams in the implementation.
- Cancer Care Coordinators (each breast site and one at Stockport for the colorectal site).

- Project Manager and Clinical Lead

Progress and Roll Out Proposals

Breast Personalised Stratified Follow-up

Bolton – Go Live date for pathway 1/1/20. Cancer Care Coordinator post out to advert, interview date 25/11/19. Task & Finish Group established and meeting fortnightly.

Tameside and Glossop – pathway went live on 1/9/19, Cancer Care Coordinator in post, interim IT solution (Lorenzo) identified, Task & Finish group established and meeting regularly.

Stockport – offering Stockport breast cancer patients personalised stratified follow-up was in the original project PID prior to the service's closure. Agreement has been obtained through the GM Cancer Programme Assurance Group for the project to support MFT to offer Stockport patients personalised stratified follow-up. A meeting has been arranged for 27/11/19 to established details of the support needed to enable this.

Wigan, Wrightington and Leigh - Go Live date for pathway 1/1/20. Cancer Care Coordinator post due out to advert. Task & Finish Group established. Implementation of IT on priority work programme.

Colorectal Personalised Stratified Follow-up

Stockport - Cancer Care Coordinator post recruited. Joint workshop with Trust Service Improvement Team to establish vision for service arranged for 5/12/19. Task & Finish Group established and meeting regularly.

Salford – Joint work underway with Project Team and Colorectal Cancer Team to develop framework for Implementation Toolkit and to standardise elements of the service so that it is equitable to the breast personalised stratified follow-up pathways already in place (e.g. uplift and upskill of Cancer Care Coordinator).

IT Solution

Project working with The Christie Procurement Department to procure InfoFlex centrally via Framework. Links made with IT Teams at each Trust and work underway to ensure implementation of IT solution a priority on IT Work Programmes at each Trust. Work underway to establish best use of project resources to ensure implementation of IT solution happens swiftly and to target date at each Trust. Links made with Digital Team at GMHSCP to ensure IT for this project fits with over-arching GM IT strategy.

Measures of Success

Moving to this model will enable around 50-70% of breast and 50% of colorectal patients to self-manage with support, requiring only imaging or biochemical surveillance, and patient initiated contact as required. Clinically valuable surveillance tests are uncoupled from routine outpatient follow up appointments, and can often be carried out in community settings, reducing the amount of time patients take off work or away their preferred activities to attend appointments and providing better patient experience.

Project:	**CAN-Guide (Supported Decision Making around Palliative Chemotherapy)**
GM Cancer Leads:	Janelle Yorke

Summary of Project

Following a successful small Greater Manchester pilot of an enhanced-decision making package called the 'Goals of Care Initiative (GOCI)', we are now setting up an innovatively designed research study to formally evaluate the GOCI tool when used widely in a clinical setting. 800 patients will be studied over 2 years (in 7 types of cancer) from May 2019 with the hope that, if successful, evidence will be developed which supports broader roll out in GM and

beyond as part of a standardised approach. The overall aim of the Can-GUIDE programme is to improve the way information is presented to patients with progressing cancer about the benefits and risks of further systemic treatments (chemotherapy and biological agents), and empower patients to fully engage in shared-decision making.

Progress and Roll Out Proposals

Data collection to establish a baseline of patient involvement in Shared Decision Making prior to the first wave of implementation of the GOCI is continuing. This has involved clinics within the lung, sarcoma, renal, gynaecology, colorectal and breast disease groups. Increasing numbers of clinics are taking part, which is now being supported by the appointment of two new members of staff. In addition, support is being given by the Observational and Supportive Research Team.

Work on the content for the Can-GUIDE website and accompanying booklet has continued. The booklet is to go to the graphic designer in November, in preparation for the first wave of implementation in early 2020. Filming for the website, which will be launched at the same time, is being completed.

Conversational frameworks, which will be used in the clinician training for the Can-Guide, are being developed with NHS England.

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

Summary of Project

The Cancer Education project will work with all stakeholders across the GMHSCP (in health & social, voluntary, charitable and community) to create opportunities for equal access to education for cancer care givers across GM & EC. The aim is a collaborative system wide approach to workforce development; upskilling the workforce, resulting in better patient experiences across the region, as a trailblazer for the NHS nationally. The project recruited the Director of Education (Catherine Heaven) in September 2018, and Education Programme Manager (Rachel Hickson) started in role in April 2019.

This two year transformational education programme has three core elements:

- Creation of an education transformation team
- Dedicated cancer education leadership
- Ongoing development of GatewayC, educational events and other innovative methods of delivering education across GM & EC.

Progress and Roll Out Proposals

- Scoping work has drawn to a close, allowing for the Project Definition Document to be completed including objectives and deliverables for the programme. The PDD was approved by the Project Assurance Board in August, and the objectives/deliverables presented to the GM Cancer Education Board. The Education team can now start to operationalise the deliverables.

- Continued facilitation and delivery of educational events that are free and accessible to the GM & EC health and social care workforce. Events this reporting period; Gynae event for CNS's or equivalent key workers, LWAB for primary care, Head & Neck symposium.

- GM Cancer mailing list platform continues to grow, as well as followers and engagement with @GMCEducation.

- Supporting the Best Timed Pathway projects by proposing a GM offering for new and existing Cancer Navigator roles; knowledge sharing with other CA's has taken place, along with advise from stakeholders. The proposal and speakers are being developed/approached at present.

- MDT Coordinator training requirements have been explored and there is enough overlap with the Cancer Navigator training mentioned above, to warrant a combined training offer for both roles. Cancer managers are on board with releasing staff to attend training. The training proposal and speakers are being developed/approached at present.

- Advanced Communication: Met with GM Cancer Psychology Clinical Lead to discuss findings from scoping and next steps. Quote negotiated and approved with Maguire to deliver 10 sessions, with a maximum of 8 people per session. Potential dates have been identified and are currently being matched up with free venues. The aim is for the first session to run in January 2020, and then at regular intervals through to January 2021 across various locations in GM & EC to ensure equality of access. Lead Cancer Nurses will be notified of how many places they have been assigned for various dates, and are to allocate these to CNS's or equivalent key workers (with a minimum of 6 months experience in role) who will then go on to be assigned a place on the Psychological Level 2 training we are also funding.

- Psychological Level 2: Met with GM Cancer Psychology Clinical Lead to discuss findings from scoping and discuss challenges and potential ways forward. Names were identified as possible trainers, and these trainers have been approached to understand if they have capacity to deliver a session of training within their role. Free venues have been identified to host the training across GM & EC for equal access, and dates will be discussed in the coming weeks. Supervision on completion of the training is our biggest challenge; Lead Cancer Nurses will have to ensure that this support is in place as a pre-requisite for the funded training places to be offered. They will then be notified of how many places they have been allocated for various dates, and are to allocate these to CNS's or equivalent key workers who have completed Advanced Communications training 3-6 months previous as a minimum.

- GMCC preparations and Committee meetings continue; agenda complete, speakers briefed, venue visits complete, logistics in place, team briefing complete, on the day volunteers identified, floor plans complete, social media content is regularly planned and executed including content scheduled for throughout the two day event. At the time of writing this report, the Conference is one week away and it is set to be a fantastic showcase of the work going on in GM.

Collaborating with the Macmillan Greater Manchester Lymphoedema Programme to create a video-graphic for Skin Care Management. Initial conversations have taken place to understand objectives, content and usage across various teams. We will demonstrate how we work across the system and departments to ensure real value for money; this one video will be used by the GM Cancer Education Programme, Macmillan Greater Manchester Lymphoedema Programme, and by Gateway C – covering both healthcare professional and patient education. Kick off meeting with the TEL team at the School of Oncology has taken place to understand if our vision can be achieved; positive response from the TEL team who will be producing this for us. Content is being provided by the GM Macmillan Clinical Lead. The completion date aim is mid-end January 2020.

- Skills Passport for Care Homes & Hospices: Initial top line meeting held with various stakeholders who have all mentioned an interest in a skills passport previously, to understand everyone's vision and aims for collaborating on a GM Skills Passport for Care Homes and/or Hospices. The idea is for essential training to be delivered in a Skills Passport recognised across GM & EC, which would reduce time re-training when staff move, which in turn reduces costs, as well as helping to retain staff and ensure they feel valued/invested in. Next steps are to identify the best way forward and what the proposal will be.

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

Summary of Project

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

The project seeks to build towards being a national exemplar in demonstrating actionable insight and world class business intelligence. Over the next 5 months the team will be working towards some key milestone to ensure the service is positioned where it needs to be to realise this ambition.

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

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

Progress and Roll Out Proposals

- Graham Beales presented a lunch and learn session to the GM Cancer team, giving an introduction and overview of the GM Tableau system.
- Power BI 'Portal' has been retired, with content being developed on the GM Tableau server as a new source of information.
- 2 Week wait and 62 Day wait provider / commissioner performance reports released on GM Tableau as first draft. (Awaiting identified issue on 62 day to be resolved at data layer, Fix ETA 18/11/2019)
- GM Cancer Analysts to attend Tableau training in November 2019.
- GM Cancer data warehouse manager appointed via contractor until 31/03/2020.
- Continuation of development of best timed pathway logic against patient level data
- Discussions with NHSD around identified issue with patient level data not being available as a full provider / commissioner split.
- GMHSCP information governance sign off due before end of November 2019 enabling

the wider GMHSCP BI Team access to the patient level data.

- Further GM Cancer performance reports expected to be delivered across November 2019.
- Initial GM Cancer Board report developed early December 2019.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number

11

Greater Manchester Cancer

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	28th October 2019	
Title of paper:	Best Practice Pathways for (1) Head and Neck, (2) Gynaecology and (3) HPB	
Purpose of the paper:	To update the GM Cancer Board on the development of accelerated pathways for (i) Head and Neck, (ii) Gynaecological and (iii) Pancreatic, Bile Duct and Ampullary Cancer summarising the engagement undertaken so far and proposed actions / key issues.	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	✓	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes	The paper updates the GM Cancer Board on the outcome of the initial work to develop accelerated pathways for (i) Head and Neck, (ii) Gynaecological and (iii) Pancreatic, Bile Duct and Ampullary Cancer, with the key aims to improve outcomes, patient experience and reduce variation across GM.	
Improved patient experience	Improving outcomes and access, and reducing variation are two key factors in patient experience, addressed by the pathway design work and engagement exercises outlined in this report.	
Reducing inequality	The delivery of the GM Cancer Plan is heavily predicated on demonstrating a reduction in inequality across the system.	
Minimising variation	The process of developing accelerated pathways for (i) Head and Neck, (ii) Gynaecological and (iii) Pancreatic, Bile Duct	

	and Ampullary Cancer, outlined in this report have enabled variation to be identified and best practice for minimising it acknowledged.
Operational / financial efficiency	Delivery via commissioning infrastructure of the financial and operational efficiencies described in the GM Cancer Plan.
Author of paper and contact details	**Name:** Rachel Allen **Title:** Pathway Manager **Email:** rachel.allen12@nhs.net **Name:** Michelle Leach **Title:** Pathway Manager **Email:** michelle.leach1@nhs.net **Name:** Claire Goldrick **Title:** Pathway Manager **Email:** claire.goldrick@nhs.net

8 Context, purpose and progress

This short report follows the directive of GM Cancer Senior team (SMT) to encourage clinical teams to co-design a series of accelerated diagnostic timed pathways for (i) Head and Neck, (ii) Gynaecological and (iii) Pancreatic, Bile Duct and Ampullary Cancer. Such pathways would enable patients to receive a standardised diagnostic workup, with a streamlined timetable and a shorter time to diagnosis.

Evidence indicates that improved survival and outcomes would be achieved by more rapid detection, referral, diagnosis and treatment.

Previous accelerated pathways in Lung/ colorectal/ prostate and OG cancer were agreed nationally in April 2018 and are currently being implemented across England (& in GM).

NHSE have not described a process for the development of further timed pathways and the national cancer team have suggested that alliances develop pathways themselves using the same principles.

GM Cancer Senior team have proposed the 3 pathways as set out above, as being the next priority due to difficulties meeting the cancer waiting standards in these specialities and due to the relatively high volume of referrals/ necessity for prompt diagnosis. These pathways have been described as a priority by our people affected by cancer group.

Radical improvement in early diagnosis will:

- Improve the ability of the GM Cancer system to meet and improve upon national NHS England 28 day faster cancer diagnosis standards.

- Reduce the variation in time to diagnosis and access to fast track surgery and oncology treatments and palliative care, which would in turn impact on cancer waiting times
- Reduce the variation in care by having a single standard way of diagnostic workup.
- Facilitate the future delivery of rapid diagnostic centres by having an established standard timed pathway for implementation

Investment is likely to be available to transform these pathways of care via the long term plan funding though other funding streams could become available. Sustainable funding for these pathways, if implemented, would come from locality based discussions

Process:

In the 3 clinical areas described above, Pathway Clinical Leads and Pathway Managers:

1. Were invited to submit an initial outline proposal of an accelerated pathway in July 2019. These initial proposals outlined a high-level summary of the rationale and case for change and an estimate of the financial investment required to enable transformation. Pathway teams were subsequently requested to provide further, more comprehensive detail in September.

2. Held dedicated Pathway Board meetings in September 2019 for the respective disease areas, to clinically agree a provisional optimal timed pathway from referral through to first definitive treatment to comply with the NHS England 28 day faster diagnosis target[2]. Through the collaborative Pathway Board forums, stakeholders have been encouraged to consider transformation and different ways of working to design ambitious pathways of care.

3. Gathered intelligence from the Cancer Managers Forum in order to crystallise the resource requirements to implement these radical pathways across the conurbation. Further work is still required to understand each Trust's requirements to implement the pathway in terms of human resource and system capacity.

4. Coordinated a GM-wide Stakeholder engagement event to consult and get further engagement on the proposed pathways: A system-wide stakeholder engagement event was held in October 2019 led by the GM Cancer Medical Director, the Assistant Medical Director and Pathway Managers. 91 delegates attended the day, which included representation from Pathway Boards, Cancer Managers, Directors of Operations, Lead Cancer Nurses, commissioning representatives, and people affected by cancer. Primary care representation was present but limited. At the event learning from other pathway development (nationally and locally) was shared, and dedicated roundtable discussions were held for each of the three pathways.

9 Summary of each pathway and the key discussion points

[2] This target will be introduced from March 2020 for all Trusts, nationally.

a. Head and Neck Cancer	
GM Cancer Leads:	**Dr David Thomson – Clinical Lead for Head and Neck Cancer** **Rachel Allen – Pathway Manager for Head and Neck Cancer**

The breakout conversation followed a detailed discussion at the GM Cancer Head & Neck Pathway Board which was held in September.

Principally, patients are referred into the pathway with worrying symptoms by the GP or because they have a neck lump which needs investigating. This is the basis of how the pathway splits: lateral neck lump pathway; worrying symptoms pathway. 'Lateral' neck lump is used to differentiate from thyroid nodules, which is a different pathway.

The pathway is MDT at day 21 and clinic by day 28 which will allow for standardisation across the region which is important for aligning with NHS England's Find Out Faster target and for benchmarking processes. MDT will take place on day 21 as per the headline GM Cancer standard (this is a change to what was agreed at the Pathway Board in September). Patients will routinely be seen in clinic straight after the MDT (on day 21) to be informed of their treatment options. For complex patients, the additional time between day 21 and day 28 offers a buffer of flexibility for further diagnostic investigations to take place, prior to the patient attending clinic on day 28.

The first principle of the pathway is to ensure high quality referrals. The HS205 form was recently reviewed by the Pathway Board. There was minor refinement to it. The Board intend to review the form again over the next few months.

The second principle is optimal referral triage. The intention is to have further discussions with stakeholders as to whether GPs can slot patients into clinics directly (via advancements in informatics), taking a step out of the pathway. It was noted that the triaging process is quite complex and patients need to be listed for the correct clinic in a timely manner. It was suggested that the triaging process did not have to be undertaken by a consultant. Whilst it should be clinically-led, there are several roles that could lead on this responsibility. Triage needs to take place in the first or second day of the referral being received. Patients need to be seen in an appropriate clinic within 5 days. Diagnostic bundles within the initial clinic would be helpful. The implication of diagnostic bundles is that a number of tests are being requested at once, scans must be cancelled if they are not needed as capacity is limited for certain tests e.g. PET-CT. A Cancer Navigator will be responsible for this component of the pathway. Patients will also be given scan dates at their first clinic appointment which offers expediency but also offers reassurance to the patient.

The importance of flexibility with the pathway timeline was emphasised. There should be broad targets encompassing two or three goals within each stated timeframe, e.g. indicating a day 1-10 target as opposed to day 1-5; 6-10. Individual trusts can then manage these processes. For example, time to investigations and communication of results, or time from clinic to MDT discussion can be achieved together.

15 days from when the patient is seen, to performing the EUA/biopsy and histopathology results being available was thought reasonable.

In terms of enablers for this pathway or practicalities, logistics should be optimised, e.g. samples delivered from theatre to laboratory immediately after surgery, rather than at the end of the day. Communication between referrer and radiologists or pathologists as to the required turnaround for results is important. Where appropriate, patients should be stepped down at all stages of the pathway i.e. from suspected cancer pathway to a non-urgent pathway. The Cancer Navigator will be important in communicating the stepping down of patients. Considering the day of the MDT is important so that clinicians can manage their pathway appropriately.

An important issue was raised around centralisation. At a number of points on the pathway, there may be consideration (if Trusts are struggling locally) to operate certain services in one location, such as ultrasound fine needle aspiration of a neck lump, or cytology reporting. Before this is decided, there need to be an understanding of what is happening at each local site. Process mapping at each stage of the pathway at each centre would be helpful to understand the bottlenecks and decide whether they can be helped by partnering with a neighbouring site allowing some degree of centralisation.

An overview of the final pathways can be found in appendix 1 and 2.

b. Gynaecological Cancer

GM Cancer Leads:	**Dr Lisa Barraclough – Clinical Lead for Gynaecological Cancer** **Michelle Leach – Pathway Manager for Gynaecological Cancer**

The breakout conversation followed a detailed discussion at the GM Cancer Gynaecology Pathway Board which was held in September where 4 pathways were discussed for suspected cancer of the cervix, endometrium, vulva and ovaries with the main principle of MDT at day 21 and clinic by day 28.

The dialogue opened with a presentation on suspected cancer referrals (SCR) undertaken by Trust representatives on the pathway boards (appendix 3.). This was presented as the gynaecologists feel overwhelmed by incomplete referrals and feel that freeing up time at this stage of the pathway would help for a smoother transition in secondary care. It was felt that a review would help to identify common themes and hence look towards solutions. These could be to guide education, be clearer with the wording of the SCR forms and look at alternative approaches to providing specialist gynaecological opinion in secondary care such as pic safe for suspected cervical and vulval cancers to help with triage which was included in the original funding bid.

It was also discussed that the SCR forms are built such that all boxes have to be completed correctly and scan reports/bloods results attached before the form can be submitted. This would be pathway board and primary care joint initiative and potentially result in huge improvements in efficiencies but is reliant upon the GP IT systems.

The group moved on to discuss the developed pathways and whilst they were felt to be clinically appropriate it was discussed that this be developed further into 2 pathway one for post-menopausal bleeding and one for all other suspected gynaecological cancers and the importance of a band 7 CNS and also patient trackers in this process *or* focus solely on the ovarian pathway which seemed to be where most issues occurred from the results of the audits carried out. This would mean the pathways would need further work and discussion at the pathway board on the 1st November.

Pathology issues were debated and the work up carried out in the units was discussed so that the specialist centres can review in a timelier manner as they cannot currently meet the SMDT by day 21 standard. The histopathology standard document has already been produced ready for ratification at the next pathway board.

RISK: Dr Barraclough is stepping down from her role as Clinical Lead and her last day on behalf of GM Cancer will be at the November Board. Currently recruitment to this post has been unsuccessful. Whilst we will endeavour to sign off an agreed updated proposal at the November Board, strong clinical leadership is required to drive this forward.

c. Pancreatic, Bile Duct and Ampullary Cancer	
GM Cancer Leads:	**Mr Thomas Satyadas – Clinical Lead for HPB Cancer** **Claire Goldrick – Pathway Manager for HPB Cancer**

Over half of people with pancreatic cancer die within 3 months, a quarter die within a month of diagnosis and only 10% of pancreatic cancers in the UK are resected. The vast majority of patients receive a palliative/best supportive care diagnosis. These large cohorts of patients are not provided the same opportunities to access interventions such as Prehab as they are not in a surgical pathway.

The proposed 14 day emergency diagnosis pathway (appendix 4) attempts to address these aforementioned issues. Radical improvement in early diagnosis is essential to increase access to treatment and improve patient outcomes in this disease area. There is also an opportunity to provide earlier and more streamlined palliative care support by linking in hospitals and community palliative care input.

The Pathway Board held in September focused entirely on the 14 day emergency diagnosis pathway and was approved at the board following extensive engagement with stakeholders including people affected by cancer, consultants, radiology, pathology and nurses. The group discussion on 14th October concluded with the group agreeing that although challenging to implement this emergency diagnostic pathway is the right thing for this group of patients. There were some key discussion points:

- Almost 40% of pancreatic cancers are diagnosed via an emergency route. Focused advice and education is needed for primary care in what to do for patients with suspected HPB cancers. Clear routes of referral are needed for patients for GPs and urgent care to one-stop/next day clinics.
- Further discussion needed on the link to RDCs and how this could be utilised for the

pathway.

- Workforce: there were discussions around utilising the current workforce in a different way e.g. staff nurses.
- The group agreed the principle of providing INDASH + Research (Information, Nutrition, Diabetes/Depression, Analgesia, Stenting, Hereditary) support for all patients especially all patients receiving dietician input.
- Radiology: further exploration needed on how emergency referral to sMDT would work in terms of radiology. Pathway Board have discussed the idea of moving to a sector based approach as current operations would not support all Trusts supporting this emergency pathway.
- The patient representatives noted the importance of having clear communication through a potentially very quick diagnostic pathway. The group discussed the importance of the navigator and co-ordinator role to act as a constant contact for the patients.

CG acknowledged that the proposal included extensive patient experience data collection to ensure that this emergency pathway is both feasible and acceptable to patients. The group agreed that though potentially difficult for patients, the emergency pathway would provide faster access to treatments for patients.

10 Key Findings and Themes - Summary

Initial findings and common themes from the three breakout sessions include:

- **Further engagement**: Further engagement is required with the Pathway Board forums particularly as the discussions at the October Engagement Event led to modifications to the pathways endorsed by the Pathway Boards in September. Further collaboration is also required with the Cancer Managers Forum to understand Trust's requirements to implement the pathways in terms of human resource and system capacity. Wider engagement with primary care colleagues is essential particularly given the drive for radical improvement in early diagnosis for these three pathways of care. Input at the October Stakeholder Engagement Event was limited to one GP, and primary care contributions to the bespoke Pathway Board discussions on accelerated pathways have been minimal to date.

- **Workforce:** Common issues have been reported across all disease areas relating to diagnostics, radiology, and pathology capacity. Collaboration with the GM Cancer Workforce Lead and Programme Director for Performance will be significant**.**

- **Resource:** Further development of the three pathways will lead to clarity on which Trusts will deliver on specific elements of the pathway through centralisation of services for example (if not all). From this, resource gaps will be highlighted.

11 Next steps

As referred to above, following the detailed findings of the breakout discussions and engagement work, there are some initial key proposed pieces of work arising which are as follows:

- **Financial support:** Secure appropriate investment to support implementation of these three pathways.

- **Further engagement:** As outlined above in section 3.

- **Gap analysis:** A greater understanding of the current clinical pathway in comparison to the proposed optimal pathway for the three disease areas is required, with in-depth analysis of capacity, demand and processes across the conurbation. From this, a more precise and realistic investment ask to support implementation of these projects can be articulated.

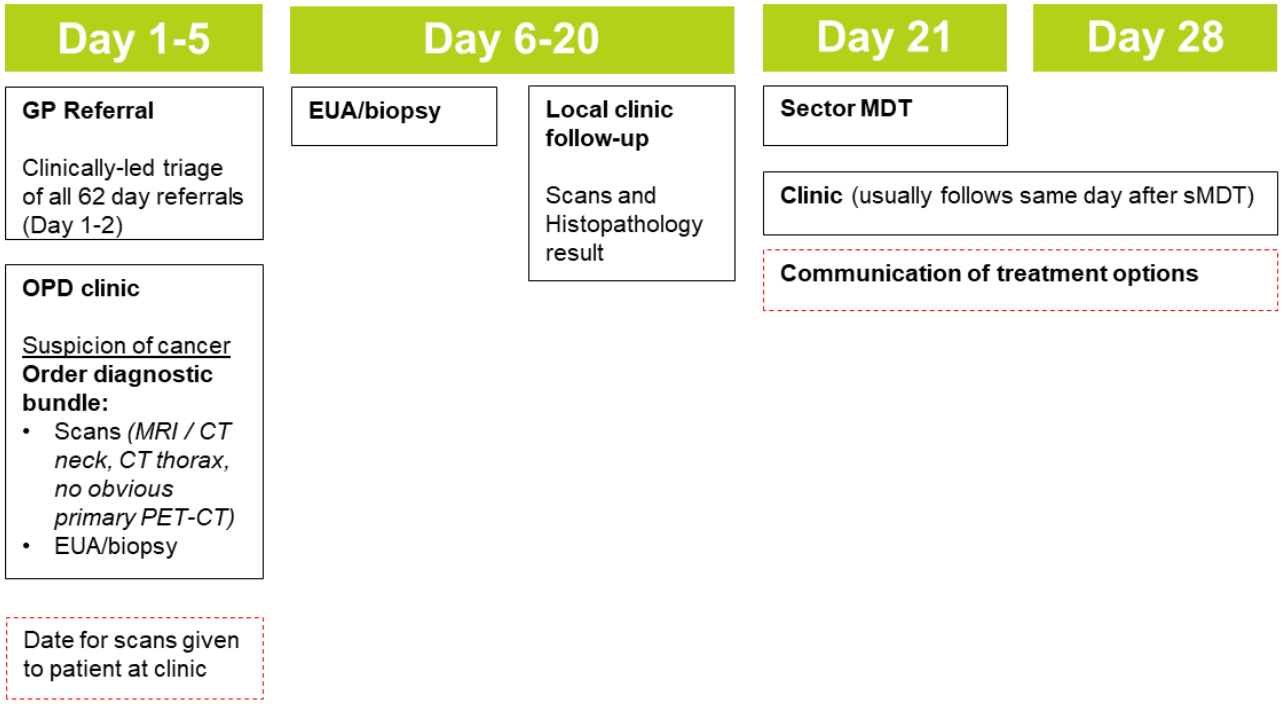
- **Recruitment:** The open appointment of a dedicated clinical lead and transformation project manager for each pathway is required, all working closely at the alliance level. Dedicated leadership with energy, persistence and faith is a key point of learning from the Transformation Wave 1 cohort of optimal pathway projects.

12 Recommendations

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

Appendices

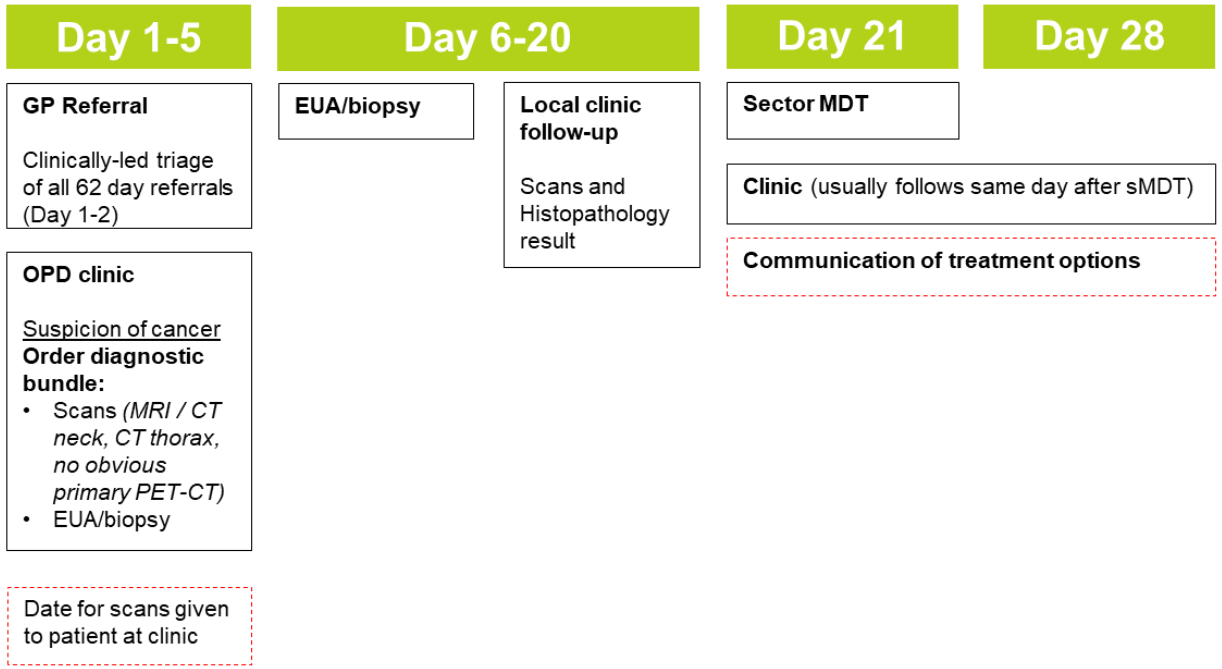
Appendix 1 - Suspected Head & Neck Cancer: Lateral Neck Lump – 28 Day Pathway



- Diagnostic bundles: where test(s) no longer required, these are to be cancelled
- Cancer diagnosis not suspected or excluded – step down from urgent pathway

Maximum target times provided

Appendix 2 - Suspected Head & Neck Cancer: Worrying Symptoms – 28 Day Pathway



- Diagnostic bundles: where test(s) no longer required, these are to be cancelled
- Cancer diagnosis not suspected or excluded – step down from urgent pathway

Maximum target times provided

Appendix 3

Greater Manchester **Cancer**

DRAFT Endometrial, vulval & cervical Cancer Pathway

Day 1	2 - 7	8 - 14	15 - 21	28 - 38
GP Referral to one-stop clinic for suspected gynaecological cancer	**Endometrial**: Attend clinic +/- USS, hysteroscopy, biopsy & patient informed of pathway or discharged if normal results	**Endometrial:** Biopsy results available GA hysteroscopy if necessary Request appropriate imaging – CT/MR If normal results - discharge	**Endometrial:** SMDT *including TYA input as required.* Clinic/ phone call & CaRP to tertiary centre as per SMDT (*TYA treatment plan confirmed)*	**Endometrial:** Treatment at local unit or tertiary centre for specialist surgical or non-surgical intervention
	Cervical: Attend clinic with colposcopy. LA biopsy performed (*TYA assess suitability based on maturity)* *If obvious/suspected cancer request MRI and GA biopsy if unable to perform under LA* Normal results – discharge patient	**Cervical:** GA/LA Biopsy reported clinician informed. Request MR if not already done	**Cervical:** SMDT *including TYA input as required*	**Cervical:** OPA – patient informed of pathway *CNS to contact TYA team at Christie regarding potential patient* Clinic/ phone call to inform patient of treatment plan CaRP for surgery at St Mary's/Christie (*TYA admission /treatment plan*)
	Vulval: Attend clinic +/- biopsy & patient. Request imaging as appropriate *CNS to contact TYA team at Christie* Normal results – discharge patient	**Vulval:** Biopsy results available. Request imaging as appropriate. Biopsy under GA if required – if normal see in clinic and discharge patient	**Vulval**: SMDT *including TYA input as required* Clinic/ phone call & CaRP (*TYA admission/treatment plan CaRP to Christie)*	**Vulval**: Treatment at tertiary surgical centre or non-surgical oncology/ *TYA at Christie*

Maximum target times provided

Greater Manchester **Cancer**

DRAFT Ovarian Cancer Pathway

Day 1 - 7	8 - 14	15 - 21	22 - 28	28 - 38
GP Referral straight to CT/MRI *referral should include CA125, CA 19-9 if appropriate and USS *TYA will require LDP, AFP, HCG and inhibin*	**CT/MRI reported**: Tumour markers noted Consider omental biopsy if appropriate e.g. if extensive serosal disease/ significant co-morbidities ↓ **If normal results - discharge**	**SMDT –** including *TYA input as required* Not suitable for surgery – needs further investigation. Further imaging/biopsy as appropriate. **Re-discuss in SMDT**	**Patient seen in OPD and informed of pathway**.	**CaRP to The Christie for non-surgical treatment or surgery at central specialist surgical centre.** ***TYA admission/ treatment plan to be confirmed***

Maximum target times provided

Appendix 4

Greater Manchester Cancer

DRAFT Pancreatic, Bile Duct and Ampullary Cancer Pathway

Day 1 - 3	4 - 5	6 - 10	11-13	14
Initial referral: GP Referral*/A&E *Triage of GI suspected cancer referrals	**Daily Fast Track MDT**: determine patients suitable for surgical/ oncology treatment and patients for supportive care	**Diagnostic Interventions including INDASH e.g. Biopsy, ERCP, PET Scan**	**Outpatient Appointment at treating centre (Surgery/Oncology/ Best Supportive Care)**	**Definitive Treatment: Surgery/Oncology**
CT Scan (Reported within 24 hours) **Patient pathways include:* - *Jaundice Clinic* - *A&E* - *Secondary Care referral*	Communication to referring Trust/Clinician	Histology reported within 4 days		
Referral to Fast Track specialist MDT	**Outpatient Appointment:** Patient communication to discuss Diagnosis/ Treatment options, with CNS support **INDASH Assessment + Research:** Information Nutrition Diabetes/Depression Analgesia Stenting Hereditary	Cytology reported within 3 days **MDT: All patients discussed at smaller MDT to be listed on main MDT for audit purposes**		
	MDT Outcome Actions: - Referral to Oncology/Sugery/BSC - Book diagnostic interventions			

Maximum target times provided

GMCA GREATER MANCHESTER COMBINED AUTHORITY

Paper number

11

NHS in Greater Manchester

Greater Manchester **Cancer**

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	**28th November 2019**	
Title of paper:	**Overview of the Richards Review of Adult Screening Programmes in England (published 16th October 2019)**	
Purpose of the paper:	To provide the GM Cancer Board with a brief overview of the Professor Sir Mike Richards Report on the Review of Adult Screening Programmes in England, and the proposed actions to deliver improvement in Greater Manchester	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	☐	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient experience and outcomes **Reducing inequality** **Minimising variation** **Operational / financial efficiency**	The Richards' Review states that the combined five UK adult programmes save around 10,000 lives a year through prevention and early diagnosis and while they give us much to be proud of, they are far from realising their full potential. This briefing outlines the key recommendations from the report and how we will progress these in GM which should seek to address reducing inequality, minimising variation, and improving patient outcomes.	
Author of paper and contact details	**Name:** Siobhan Farmer **Title: Public Health Consultant, GMHSC Partnership** **Email:** siobhan.farmer@nhs.net	

Greater Manchester Cancer Board

Date: 28th November 2019

Title: Overview of the Richards' Review of Adult Screening Programmes in England

From: Siobhan Farmer, Public Health Consultant, GMHSC Partnership

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Key Messages

- The strategic aim of the Richards' Review was to assess strengths and weaknesses in the current commissioning and delivery arrangements for the five national adult screening programmes in England, to ensure that screening programmes are transformed for the future to reach their full potential.
- The scope of the review included the Breast, Bowel and Cervical cancer programmes, Abdominal Aortic Aneurysm (AAA) screening, Diabetic Eye Screening Programme (DESP, noting that this extends to young people from the age of 12).
- The review was published on the 16th October 2019 and makes 22 recommendations to the NHS England Board and the Secretary of State; the final terms of reference were published alongside the report.
- A key recommendation pertains to the oversight of delivery of all aspects of screening and recommends that this should become the responsibility of a single organisation, namely NHS England. Furthermore, that staff with specialist screening roles such as screening quality assurance should transfer to NHSE. The report is unclear on the implications to screening and immunisation teams.
- An implementation action plan will be published in spring 2020.

Background / Context

Professor Sir Mike Richards' Review of Adult Screening Programmes in England was commissioned in November 2018 as a response to the increased scrutiny that cancer screening programmes were under from national screening incidents. The remit was "to assess current strengths and weaknesses in the current commissioning and delivery arrangements for the national cancer screening programmes in England, in view of the current available evidence.''

Following publication of the interim report in March 2019 and the Public Accounts Committee session on adult screening, the review scope was extended to include all screening programmes which target the adult population and require people to be actively called and recalled for screening:

- Abdominal aortic aneurysm (AAA)
- Bowel cancer
- Breast cancer
- Cervical cancer
- Diabetic eye screening (DES; this also extends to young people).

The report of the review was published on 16 October 2019 on the NHS England website. The Review reported to NHS England and to the Secretary of State for Health and Social Care. The final terms of reference were published alongside the report. The report states that the combined programmes save around 10,000 lives a year through prevention and early diagnosis and while they give us much to be proud of, they are far from realising their full potential.

In Greater Manchester, these programmes are commissioned by the Greater Manchester Health and Social Care (GMHSC) Partnership, as part of the NHSE functions delegated to the system under the devolution agreement. All GM programmes are currently underperforming compared to the national expected standards, albeit very few areas of the country meet or exceed these standards, and for all three cancer screening programmes, the gap to the England average is getting narrower even when the population growth in the city region is factored in. However, it is recognised that screening needs continued concerted investment of effort and resource to continue to improve in Greater Manchester, especially if we are to address the significant internal inequalities in uptake and coverage across GM.

Richards Review Recommendations

There are 22 recommendation in the report to the NHS England Board and to the Secretary of State which are being considered. A summary of these recommendations is in the table below:

- Governance - recommendations 1-10
- Information systems - recommendations 11-12
- Uptake and coverage - recommendation 13
- Wider performance issues - recommendations 14 – 16
- Financial incentives - recommendation 17
- Creating capacity - recommendations 18 – 21
- Improving audit and research - recommendations 21-22

Following publication, a Written Ministerial Statement then stated the following:

- DHSC will work closely with Public Health England (PHE) and NHS England to ensure functions are located in the best place to deliver a high-quality service, building on the joint work that both organisations have already been implementing.

- Screening programmes should receive independent external scrutiny and DHSC will continue to work with PHE and NHS England to design an optimum quality assurance process.
- There will be a single source of national expert advice on both population-wide and targeted screening. PHE hosts world-class scientific and expert advice on screening and will host this function, building on its current role providing support to the UK National Screening Committee.
- The Chief Medical Officer for England, Professor Chris Whitty, will work with his counterparts across the UK to consider the detail of the proposed new advisory mechanism and how it could meet the needs of all four UK countries. Extending and consolidating arrangements for providing independent expert advice on all screening programmes, will improve delivery and exploit the huge scientific progress that is being made to deliver faster and better access to the latest and best screening interventions.
- NHS England will become the single body responsible for the delivery of screening services. The full recommendations will need further consideration, taking into account the potential impact on current service delivery to ensure any changes can be delivered safely and consistently and DHSC will develop an implementation plan, which will be published in due course.

Whilst the review considers some aspects of diagnostic capacity that are directly related to screening, its scope does not extend to diagnostic capacity more generally. This will be covered in a separate report due to be published later in 2019.

Section	Rec Number	Recommendation
Commissioning and oversight of services	**1**	**The Chief Medical Officers of the UK should bring together an advisory group** to agree Terms of Reference for a new single screening advisory body which should cover both population and targeted screening, have an effective horizon scanning function, undertake and commission evidence reviews, and model impact and cost effectiveness.
	2	Recommendations on **targeted screening should be given the same weight and funding commitments as those for population screening** and should be commissioned through the S7A agreement.
	3	**NHSE and PHE should produce a roadmap for the transfer of relevant staff with expertise on screening delivery from PHE to NHSE to support their respective future roles**. This roadmap should also consider how NHSE would integrate the delivery of targeted and population screening.
	4	Following decisions by Ministers, **NHSE should assume sole responsibility for the delivery of screening programmes,**

		appointing a named director responsible for screening, so that it is clear to all stakeholders who is in charge. This should include both the implementation of Ministerial decisions on screening and 'business as usual' matters, including commissioning, performance management, monitoring and audit. NHSE should work closely with PHE on the advice, NHSX on IT implementation and HEE in relation to workforce
	5	**The screening quality assurance service which is currently accountable to PHE should also transfer to NHSE but should be ring-fenced as part of the S7A mandate**. Local quality assurance reports and a national overview report should be published annually and shared with the CQC to inform assessments of screening service providers, with CQC taking enforcement action to address quality issues where required.
	6	**NHSE should publish an annual report** on population and targeted screening performance.
	7	**At national level, NHSE should consider how to build on existing programme board arrangements to deliver its accountability for delivering both population and targeted screening programmes** this should include expertise from PHE, NHSX, NHSD, HEE and NHSE regions and other directorates as required.
	8	**Local commissioning of both population and targeted screening should be aligned with the new regional structure of NHSE**. Regional Directors should be accountable for the screening functions within their geographical areas and should ensure their delivery against KPI's.
	9	**NHSE should consider how to improve and standardise local oversight of population and targeted screening,** bringing together the current expertise from the QA and commissioning teams. These teams will need to work closely with commissioners on relevant services for patients who present symptomatically (e.g. mammography, endoscopy, colposcopy and hospital eye services**). Local commissioning teams should be aligned as far as possible with Sustainability and Transformation Partnerships / Integrated Care Systems.** This would be assisted by proposals for planned legislation to enable national and local commissioners to work together.
	10	**Local commissioners should work closely with cancer alliances, local authorities, and emerging primary care networks** to ensure close join-up at local level.

Information systems	**11**	**NHSX should roadmap the delivery of new targeted and population screening IT systems as soon as possible**, with a primary focus on the challenges with cervical and breast screening programmes and with regular reports on progress provided to DHSC and NHSE.
	12	**The development of screening IT systems should include a focus on the functionality needed to support improvements in uptake and coverage** and consider the needs of population and targeted screening approaches.
Uptake and coverage	**13**	**High priority should be given to spreading the implementation of evidence-based initiatives to increase uptake.** This will require an integrated system approach and should include: • Implementing text reminders for all screening programmes • Further pilots of social media campaigns with formal evaluation and rollout if successful • Spreading good practice on physical and learning disabilities • Encouraging links with faith leaders and community groups and relevant vountary, community and social enterprise organisations that work with the NHS at national, regional and local levels to reduce health inequalities and advance equality of opportunity • Increasing awareness of trans and gender diverse issues amongst screening health professionals • Consideration of financial incentives for providers to promote out of hours and weekend appointments.
Wider issues	**14**	**Breast screening providers should aim to invite people at 34-month intervals after their previous appointment** so that all participants can be screened within 36 months and therefore avoid slippage.
	15	Across all screening programmes**, getting the results of screening to patients within the standard timeframes should be achieved**. Particularly for cervical screening where performance has fallen markedly.
	16	**Time to assessment and where necessary, further treatment, should be closely monitored** across all programmes and publicly reported as part of faster diagnosis standards.
Financial incentives	**17**	NHSE should urgently consider **how best to use financial incentives to increase uptake of cancer screening services** and to encourage providers to prepare for the future, especially about bowel screening.
Creating	**18**	**National guidance should be provided to allow local commissioners and providers to plan for the required**

capacity		**changes in colonoscopy and any future screening programme changes**. Commissioners of screening and symptomatic services will need to work together on this. Cancer Alliances can facilitate this working in collaboration with the NHSE public health commissioning teams.
	19	**Training of screening colonoscopists should be given very high priority** by HEE. Providing endoscopists who are already undertaking symptomatic colonoscopies with additional skills should be encouraged
	20	**A dedicated capital fund or similar approach to support the purchasing of screening equipment and facilities** should be established to replace old equipment and meet future activity increases.
Improving audit and research	**21**	**Routine audit data on each of the five adult programmes should be published by NHSE**, at least annually, including, appropriate equality data to support monitoring of uptake in under-served groups.
	22	**The process for releasing data for research purposes should be reviewed and simplified**, with timelines being set for decisions by individual committees, including the Office for Data Release. Further approval processes should be consolidated across different organisations with carefully defined remits documented for all parties, including data sharing arrangements.

Next Steps

In Greater Manchester we welcome the report and its recommendations which support our ambitions to improve the governance, quality, uptake and coverage of these vital screening programmes; they are a key part of the strategy to ensure earlier detection, diagnosis and therefore better cancer outcomes for our population. Furthermore, the review identifies the key barriers to achieving this such as capacity in the workforce; we have already ensured that our GMHSCP team is liaising with GM Cancer as part of the workforce strategy to ensure that screening resource is also considered in future planning.

Whilst we await the implementation plan to be produced by DHSC, PHE and NHSEI that will be published in the spring 2020, we recognise there is further local work to be done to support the evidenced based recommendations within this report and we will complete a benchmarking exercise against these (Dec 19).

Many of the recommendations require a national level response or additional funding. The 2020/21 commissioning intentions do contain clear indications that some aspects of the

recommendations will be enacted (e.g. recommendation 14 is clearly articulated). The capital funding suggested in recommendation 20 has also been announced nationally.

More locally, we do know that our strong system in Greater Manchester means that some of the recommendations are already happening such as working closely with cancer alliances, local authorities, primary care networks and frontline providers of screening services (recommendation 10). However, we will need to seek ongoing feedback about how to further improve these relationships.

Recommendation 13 will be our key initial focus. This suggests practical solutions such as sending text messages and social media campaigns; some of these solutions are already commissioned through services and happening, or providers are working to achieve this. Our team will work with our providers to share good practice and facilitate the commissioning of these new solutions where possible. For example, we have recently been asked by the national team to explore whether any of our breast screening providers which to receive funding to operate out of hours appointments, and we are also exploring whether we can commission specific cervical screening services through sexual health providers. We have also recently developed a Health Inequalities strategy that will inform how we work to address the lower uptake amongst specific populations in our communities.

We will provide a further update as the implementation plan become available.

PAPER ENDS