Greater Manchester Cancer Board Agenda

Meeting time and date: Monday 20th September 3pm-5pm
Venue: MS Team Virtual Meeting
Chairs: Roger Spencer

#	Item		To	Lead	Time
1	Welcome and apologies Minutes of the last meeting Action log and matters arising	Verbal Paper 1 pg.2 Paper 1 pg.10	- Approve Update	Roger Spencer	5’
2	Overview of GM Health System and Covid Impact	Verbal	Update	Dave Shackley	15’
3	Cancer Performance & Update on the GM Cancer Alliance Rapid Diagnostic Centre Programme	Presentation 1 *(Separate attachment)*	Update	Lisa Galligan Dawson	20’
4	GM Cancer Inequalities strategy / Implementation Plan	Paper 2 *(Separate attachment)*	Update	Dave Shackley / Alison Jones	15’
5	CQC Provider Collaboration Review Report	Paper 3 pg.11	Update	Claire O’Rourke	15’
6	Early Diagnosis Update	Paper 4 pg.56	Update	Ali Jones / Sarah Taylor	15’
7	Workforce strategy implementation plan	Paper 5 pg.72 Presentation 2 (*Separate attachment)*	Update	Suzanne Lilley	15’
8	Paper for Information: Virtual Cancer Week event summary Including User Involvement	Paper 6, pg.121	Update	Jane Cronin / Sinead Collins	5’
9	AOB	Verbal	Discuss	All	15’

The next meeting is scheduled Monday 22nd November 2021, 15:00pm-17:00pm

Greater Manchester Cancer Board
Minutes and Actions

Meeting time and date: Monday 19th July 2021, 15:00pm-17:00pm
Venue: Virtually, via MS Teams

Members present:

Name	Cancer Board Role	Organisation	Total attended
Roger Spencer (RS)	Co-Chair / Chief Executive	The Christie Foundation NHS Trust	3/3
Andrea Green (AG)	Co-Chair	Stockport CCG	3/3
Dave Shackley (DS)	Director & Clinical Lead	GM Cancer	3/3
Claire O'Rourke (COR)	Managing Director	GM Cancer	3/3
Susi Penney (SP)	Associate Medical Director	GM Cancer	3/3
Sarah Taylor (ST)	GP Lead	GM Cancer	3/3
Suzanne Lilley	Cancer Workforce Lead	GM Cancer	3/3
Alison Jones (AJ)	Associate Director of Commissioning - GM	GM Joint Commissioning Team	3/3
Cathy Heaven (CMH)	Programme Director of Cancer Education	The Christie NHS Foundation Trust	3/3
Alison Armstrong (AA)	Programme Lead	GM Cancer	3/3
Rhidian Bramley (RB)	Engagement Lead	GM Cancer	2/3
Ian Clayton (IC)	User Involvement Rep PaBC	Macmillan User Involvement Programme	1/3
Leah Robins (LR)	Rep for GM Chief Operating Officers	Northern Care Alliance Group	3/3
Andy Ennis (AE)	Deputy Chief Executive/Chief Operating	Bolton Foundation NHS Trust	2/3
Rob Bellingham (RB)	Managing Director	GM Joint Commissioning Team	3/3
Professor Janelle Yorke (pJL)	Executive Chief Nurse & Director of Quality	Manchester University NHS Foundation Trust	3/3

In attendance:

Name	Job Title	Organisation
Jaqie Lavelle (JL)	Senior Team Administrator	GM Cancer
Sadhbh Oliver (SO)	Senior Team Administrator	GM Cancer
Beth Sharratt (BS)	Project Manager (Health and Social Care VCSE Engagement)	GMCVO
Chris Harrison (CH)	Executive Medical Director	The Christie NHS Foundation Trust
Claire Trinder (CT)	Director of Research Strategy and Operations	Manchester Cancer Research Centre
David Wright (DW)	TYA Lead Nurse & Clinical Lead for TYA	Manchester Foundation NHS Trust
Donna Miller (DM)	Health and social care charity BHA representative	Answer Cancer
Grace McCorkle (GMc)	GM User involvement through BRAG	(BAMER Research Advisory Group)
John Moore (JM)	GM Cancer Clinical Director for Prehab and Recovery	Manchester Foundation NHS Trust
Mr Mohammed Absar (MA)	Clinical Lead, GMC Transforming Aftercare Project	Manchester Foundation NHS Trust
Lisa Spencer (LS)	Associate Director of Strategy	Northern Care Alliance NHS Group
Molly Pippng (MP)	Senior Education Events and Programme Coordinator	The Christie School of Oncology
Professor Robert Bristow MD PhD (pRB)	Director	Manchester Cancer Research Centre
Roger Prudham (RP)	Lead Cancer Clinician	NES Northern Care Alliance NHS Group
Teresa Karran (TK)	Regional NHS Relationship Manager	CRUK
Victoria Dickens (VD)	Director of AHPs	Northern Care Alliance NHS Group

Apologies:

Name	Cancer Board Role	Organisation	Total attended
Lisa Galligan-Dawson (LGD)	Performance Director	GM Cancer	2/3
Sarah Price (SP)	Chief Officer	GM Health & Social Care Partnership	2/3
Janet Castogiovanni (JC)	n/a	n/a	n/a
Steven Pleasant	n/a	n/a	n/a

Greater Manchester Cancer Board
Minutes and Actions

Meeting time and date: Monday 19th July 2021 15:00pm-17:00pm
Venue: Virtually, via MS Teams

1. Welcome and Apologies, Minutes of the last meeting & Action log and matters arising	
Discussion summary	RS welcomed all to the meeting and the apologies were noted. The minutes of the previous meeting held on 24th May 2021 were approved as an accurate record. **Matters arising – Inequalities update (AJ):** Following the GM Cancer Inequalities group meetings previously held 19th July 2021 a strategy / implementation plan is to be developed to support the delivery of the group. The aim is to complete and share an early draft at the next Cancer Board, scheduled in September.
Actions and responsibility	Minutes of the last meeting, 24th May 2021 to be uploaded to the GM Cancer Webpage GM Cancer Inequalities strategy / Implementation Plan to be shared with the GM Cancer Board members / added to the September GM Cancer board

2. Overview of GM Health System and Covid Impact	
Discussion summary	The health system is stretched with continued pressures caused by Covid and the system trying to recovery services. The pressures within the system were not just Covid related, albeit there had been an impact of workforce due to self-isolation and other services had been requested to be stepped back up, including routine work. There had also been recent breakthrough cases (typically mild cases) of Covid for those clinical staff who had received the vaccines early on. Monday 19th July was known as 'Freedom Day' as the government restrictions had been lifted and although there was another wave of Covid, a lockdown had not been presented, causing concern on what impact Wave 4 will have on the system. ▪ New cases of Covid had been estimated to 55,000-60,000 per day, compared to 30,000 cases 1-2 weeks ago ▪ Concern that recent modelling has predicted that within 2 weeks there could be 100,000 new cases per day ▪ In GM there were 2,000 new cases per day, compared to 200 - 8 weeks ago There had been an increase in the hospital impact due to the increase in Covid cases: ▪ Critical Care (CC) in GM: There were 200 patients in CC beds in the peak with the number now at 70 patients. ▪ The number of patients with Covid in the hospital system is 350 and in the previous peak was 1,500

	▪ Internationally, the impact on the NHS in terms of hospitalisation and Critical care admissions is a third of previous waves, dependant on how high the wave goes will have an impact on the hospital systems despite the vaccinations. The vaccination programme was going well; 86% of adults within GM had received their first jab and 66% their second. An agreement was yet to be reached on whether school children aged 12-17 should receive the vaccination. The GM Cancer alliance have a pivotal influencing role in GM gold and are reassured that cancer services and the recovery of these will remain a priority.
Actions and responsibility	No action required

3. Cancer Performance	
Discussion summary	**COR provided an overview of the GM current cancer performance:** During the initial waves of Covid the suspected cancer referrals (2ww) had dipped, however were now consistently above 100%. The numbers of cancers diagnosed will be tracked and presented at a future board. Prior to Covid-19 there was a significant number of patients in the backlog and we were about to enact a cancer recovery plan, when pandemic started in March 2020. There had been a national push to reduce the long waiters and a significant improvement had been made. The number of patients on combined 62-day PTLs, who were already over 62 days was 1,072 and of those 190 were over 104. This is an improved position since the report of the September board: 2,484 over 62 and 934 over 104 days. The current performance target had not been met, albeit as per previous commitment to the board there was focus on reducing the long waiters. The impact of Covid within the North West was 10% greater than other regions. Due to another wave of Covid, the cancer performance will be closely monitored via the live data feed on tableau. At the beginning of the pandemic a GM Surgical Cancer Hub was created to assist with capacity for cancer surgery and was still available for those who needed to utilise it. Surgical treatment numbers were recorded at 119% of pre-Covid activity. It was acknowledged that some providers were performing better than others and Salford had been affected by an increase in suspected skin cancer referrals. There was an overall focus on quality of referrals and due to challenges of GPs not always having face to face appointments. A Gateway C webinar is due to take place, focussed on the Skin pathway. Post-Covid Recovery Initiatives had been established with improvements in PET booking & delivery and a EBUS single queue. There remains focus on endoscopy & diagnosis, as it is where most patients are waiting. It was suggested that for future reference that sharing of cross region performance would be beneficial for comparison. The system was thanked for their continued efforts in focusing on the performance during the pandemic.

Actions and responsibility	Cross Region performance to be incorporated into future Cancer Performance Slides 2ww referrals analysis & the numbers of cancers diagnosed will be tracked and presented at a future board.

4. Cancer Spatial Framework	
Discussion summary	From April 2022 Integrated Care Systems (ICS) will be in place Nationally which will include a Greater Manchester (GM) ICS and will involve the 'closure' of Clinical Commissioning Groups (CCG's). The GM Spatial Level Engagement Workshop slides were circulated in advance of the Cancer Board meeting. It acknowledged those involved in its development and AJ alluded that all partners are to be involved & engaged as the work progresses. In the most recent National Guidance, there was reference made to the role that Cancer Alliances will have as part of ICSs. Although the slides described the principles, design, and delivery of cancer in GM there were questions raised by members of the Cancer Board, not understanding where they fit within the structure, transparency on workforce and who would be leading on cancer. It was acknowledged that the ICS development process is complex and a work in progress. The feedback received will be fed into the next discussions on ICSs. AG noted that *'the new Health Bill is currently going through the committee stage of the Parliamentary process with exact information due early next year. So, the guidance and details are still emerging but to provide assurance regarding accountability for quality of care; fundamental standards and continuous improvement; the ICS NHS Body for GM will have a statutory quality governance role as will each individual Provider as already stated in national guidance on ICS design'*
Actions and responsibility	No action required

5. Virtual Cancer Week Event Summary Including User Involvement	
Discussion summary	**Dr Cathy Heaven Director of Education, Greater Manchester Cancer & Molly Pipping Virtual Cancer Week Project Manager provided a summary of Virtual Cancer Week (VCW):** VCW had taken place between Monday 24th–Friday 28th May 2021. Each day had a different theme: living well, early diagnosis, Covid recovery, international & engaging communities. Each lunchtime participants were able to attend Prehab exercises & mindfulness sessions. There was engagement & collaboration across the system with up to 40 sessions arranged for people to attend. Due to Covid restrictions the VCW was delivered via a virtual platform, many of the sessions are available on demand to revisit. The cost of VCW was significantly lower compared to completing the event face to face and reached more people. The delegate location was aimed for those in GM & East Cheshire, however 500 of the participants were from other arears. There had since been interest from other alliances in adapting the framework.

	The sponsors of the event were: EUSA Pharma, Lilly and a grant from MAHSC There were 1,750 registered delegates & 1,303 individuals had accessed the content. The majority of those in attendance were nurses, however there was a spread of other professions in attendance across GM. There was an increase in GPs and researchers since the conference in 2018 (GPs:18, now 60, Researchers 17 now 120). There were 130 service users engaged with the event. Virtual minutes & twitter comments were including within the VCW Evaluation Report. The Service Users were thanked for the cooperation and support with VCW and Paper 2b provided an overview of their involvement which will be presented at the next board. The overall session recommendation rate across the week was 98%.
Actions and responsibility	Paper 2b VCW User Involvement summary to be presented at the September Cancer Board

6. Prehab4Cancer and recovery programme: overview of project implementation and current position	
Discussion summary	The initial purpose of the GM Cancer Prehabilitation (Prehab4Cancer) and recovery programme was to be the single referral point with GM wide coverage for access to exercise, nutrition and wellbeing support, to provide a 48-hour response and deliver free prehab & rehab to 2,000 cancer patients. This has since been achieved. The main tumour group cohorts of focus were Upper GI, Lung, Colorectal and Lung Chemo/Dxt. The journey of GM Prehab4Cancer was published by the European Journal of Surgical Oncology (EJSO) & a webpage had been created www.prehab4cancer.co.uk which has had 50,000 hits since launch in August 2020. GM health is poorer than the UK average, with more people suffering heart disease and cancer. GM was an important focus as patients are less fit, particularly in deprived areas. Service level agreement, agreed KPIs, Gym & healthcare teams were developed to provide community-based prehab and rehab, with a governance structure in place. Multimodal Prehabilitation focussed on exercise, nutritional support & mental wellbeing support to improve the patient's fitness & wellbeing prior to and post operation. Between April 2019 – March 2020 over 1,000 referrals had been received with an 80% participation rate and 94% update rate from the first appointment. A significant improvement in patient's fitness had been seen. The various waves of Covid had an impact on cancer patients & the way in which the programme was delivered, resulting in a remote service model being established. The service remained open to new referrals and personalised home exercise packs were created with online live classes available. 1,136 patients had engaged with the remote service delivery over the last year. A cost effectiveness evaluation was presented as part of the slides and it demonstrated that Prehab adds value to the GM Healthcare. Prehab4Cancer is now seen as a world-leading service and there was emphasise on the important of patients being fit.

	Members of the cancer board were supportive of the service and encouraged that the programme should be rolled out in other services, not just cancer and there is interest from the National team. A special thanks was given to the Prehab4Cancer team for their dedication to the programme during uncertain & challenging times, including to Dr John Moore as a critical care anaesthetist during the COVID pandemic & Zoe Merchant, programme lead, who has continued to oversee delivery and sustainability of the service despite redeployment.
Actions and responsibility	No action required

7. Outcomes from the GMC Transforming Aftercare Project and taking this work forward into Personalised Care	
Discussion summary	**Mohammed Absar, Clinical Lead, GM Cancer Transforming Aftercare Project & Astrid Greenberry, Programme Lead, Personalised Care for Cancer provided an overview of the GM Cancer Transforming aftercare project (Slides previously circulated):** In line with the world-class cancer outcomes and NHS long term plan the strategic drivers were to; move from the traditional hospital-based follow-up model to a more personalised and supported self-management approach for appropriate patients, allowing where suitable every person diagnosed with cancer access to personalised care. In partnership with the Macmillan Cancer Improvement partnership, PSFU (Personalised Stratified Follow Up) was already in place for Breast patients, across MFT & NCA before the project officially started in April 2019 and through the GM Cancer Vanguard for colorectal patients at MFT. The task therefore was to implement a standardised breast follow-up approach across all trusts: ▪ All trusts now have an operational breast pathway in place, the Stockport Breast Service had been closed, although the funds were redirected to MFT to provide Stockport patients with PSFU ▪ All teams have project supported Cancer Care Coordinators (all posts sustained). ▪ Patients removed from standard schedule of follow-up appointments replaced with rapid re-access back into the service as and when needed and the support of the pathway boards acknowledged to gain GM-wide agreement on protocols etc. PSFU was also implemented at Stockport, Salford and the North East Sector for Colorectal. Additional funding is now in place for the remaining colorectal, prostate and endometrial patients across GM under a new project (Personalised Care for Cancer) and test sites for all remaining tumour sites have been identified to develop a model to be further rolled out by March 2022. A new Clinical Lead for Personalised Care for Cancer has been appointed in place of Mohammed Absar as the Transforming Aftercare Clinical Lead, he was thanked for his

	leadership during the project. Additional roles will also be created to support the project going forwards.
Actions and responsibility	No action required

8. Cancer Alliance Recovery Funding 2021 - 2022	
Discussion summary	**AJ provided an update:** All cancer alliances in England received notification on 9th June 2021 in an email from Dame Cally Palmer (National Cancer Director, NHS Cancer Programme) of additional funding to accelerate and support cancer service recovery. The paper (previously circulated) provided an update on the additional funding £1.107m allocated to the GM Cancer Alliance and was detailed in Appendix 2. An expectation and criteria on what the funds should be used for was suggested and the GM Alliance submission met the requirements. The funding will support additional endoscopy and CT capacity, redesign of urology pathways and additional training to support it, amongst other things. The funding will be distributed via the ERF process with clear robust monitoring processes in place to ensure the proposals and outcomes outlines are delivered within 2021-22 and the providers are remunerated for doing so. This had been supported by Provider & CCG Directors of Finance, Provider Federation Board and Directors of Commissioning with further discussions required on the transaction process and details of providers involved.
Actions and responsibility	No action required

9. CQC Review	
Discussion summary	**COR provided a brief update:** As previously mentioned, the CQC Provider Collaboration Review of the Greater Manchester (GM) system had taken place in March 2021. There was engagement from different services within GM to demonstrate collaborative work across the system. A preliminary report had been completed and was in two sections; what was going well and areas of focus. The finalised report will be circulated once received.
Actions and responsibility	The finalised CQC Provider Collaboration Review Report is to be shared with the Cancer Board Members, once received.

10. AOB	
Discussion summary	RS noted that pressures within the system & the uncertainty of Covid-19 Wave 4 will continue, with additional challenges to be presented. He praised the important work that the GM Cancer alliance had been involved in, including the adaptation & response of changed ways of working. There were no other AOB items discussed.
Actions and responsibility	No actions required

Future Meeting Dates
The next meeting is scheduled on Monday 20th September 2021, 15:00pm-17:00pm

Action Log

Prepared for the 19th July 2021 cancer board

Log No.	AGREED ON	ACTION	STATUS
c/f 07.21	24th May 2021	**GM Cancer – National Planning** Details of the implementation of the focussed projects of work as part of the planning & reporting submission, is to be added to the agenda for the next Cancer Board meeting. (JL)	**Action Closed -** An update on the National Planning Document on cancer was provided on 24th May & a further update was given on the ICS Cancer spatial framework on 19th July
08.21	24th May 2021	CQC Provider Collaboration Review Report to be shared with the Cancer Board Members (JL)	**Action Closed -** Update provided at GM Cancer Board, Monday 19th July 2921
09.21	19th July 2021	Minutes from 24th May 2021 to be uploaded to the GM Cancer webpage (JL)	**Action Closed**
10.21	19th July 2021	GM Cancer Inequalities strategy / Implementation Plan to be shared with the GM Cancer Board members / added to the September GM Cancer board	**Action Closed** – added to the 20th September Cancer Board agenda
11.21	19th July 2021	**Cancer Performance:** Cross Region performance to be incorporated into future Cancer Performance Slides 2ww referrals analysis & the numbers of cancers diagnosed will be tracked and presented at a future board.	
12.21	19th July 2021	Paper 2b VCW User Involvement summary to be presented at the September Cancer Board	**Action Closed** – added to the 20th September Cancer Board agenda
13.21	19th July 2021	The finalised CQC Provider Collaboration Review Report is to be shared with the Cancer Board Members, once received.	**Action Closed** – added to the 20th September Cancer Board agenda

Provider Collaboration Review

Greater Manchester Integrated Care System

Cancer services

Helena Lelew, Inspection Manager

Provider Collaboration Reviews

How have providers worked collaboratively in a system in response to the COVID-19 pandemic?

More information about these reviews is available on our website

The Scope

- A focus on the experiences of people who have used and are using cancer care services and pathways during the pandemic.

- The objective is to support providers across systems by sharing learning on the COVID-19 period.

The Outputs

- Feedback for each local system – June 2021
- Insight report – June 2021
- Final report – July 2021

Key Lines of Enquiry

1. In responding to COVID-19, **how have providers collaborated** to ensure that people moving through health and care cancer services have been seen **safely in the right place, at the right time, by the right person**?
2. Was there a **shared plan, value and system wide governance and leadership** for cancer services during the COVID-19 period?
3. Was there a **strategy for ensuring the safety of staff, and sufficient skills** of staff working in cancer services across the health and care interface?
4. What impact have **digital solutions and technology** had on providers of cancer services during the COVID-19 period?

How we carried out this Review

- We carried out this review mostly during the week of 22 March 2021.
- We carried out 23 interviews (51 people) with individuals and groups such as commissioners, public health, screening services, adult social care, the NHS, GPs, dental services, pharmacists and representative of equality groups.
- We collected data from people that use services using a questionnaire/survey and reviewed a selection of GP patient records (47) at specific locations.
- The review did not assess the role that commissioning plays within the system as we do not have the legal powers to comment on the commissioning of services.

Provider Collaboration Review

Greater Manchester

Greater Manchester in Context - demographics

- The population of Greater Manchester is approximately 2.8 million people spread across 10 boroughs.
- Levels of deprivation across Manchester are varied with the most deprived areas in the north, central and east of the region especially Oldham, Bolton and Manchester.
- There are older populations in Stockport, Trafford and South Manchester. Life expectancy in Gtr Manchester -male 77.7(79.5) and female 81.3 (83.1). Trafford has the highest life expectancy -male 79.9 and female 83.5 while Manchester has the lowest male 75.6 and female 79.8.
- Manchester has a young population.
- There are areas of ethnicity across Greater Manchester but particularly Oldham, Rochdale, Bolton and Manchester and corresponding with areas of high deprivation.

Greater Manchester in Context - demographics

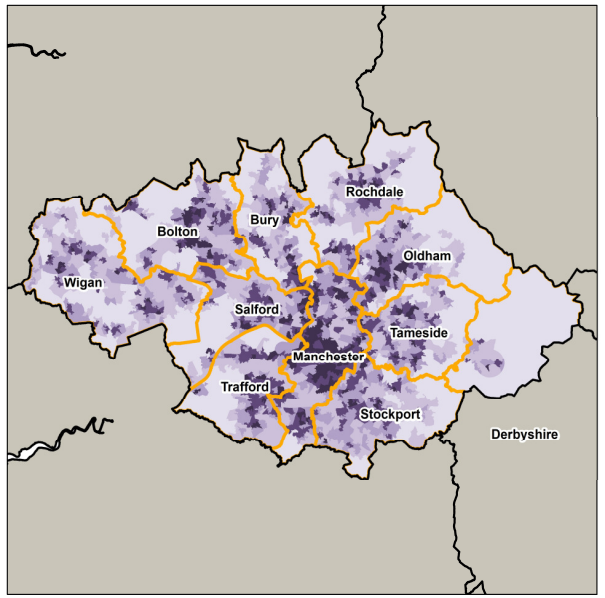
These maps show the health and social care boundaries and the built up areas of the system.

Local Authorities

Clinical Commissioning Groups

Demographic map- Population density

20% most densely populated — 20% least densely populated

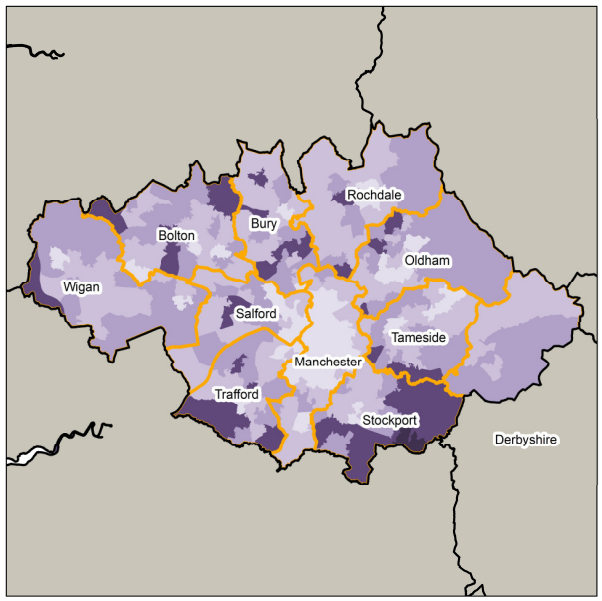


Sources: ONS- 2011; ONS- 2020; ONS- 2018

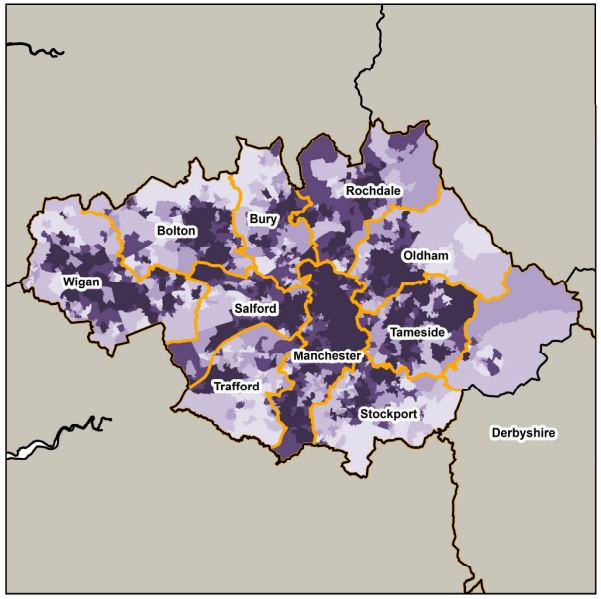
Greater Manchester in Context - demographics

These maps show the demographic context of the system with its local authorities outlined in orange. The purple shading is described in each of the separate legends and is based on a quintile scale across the whole of England.

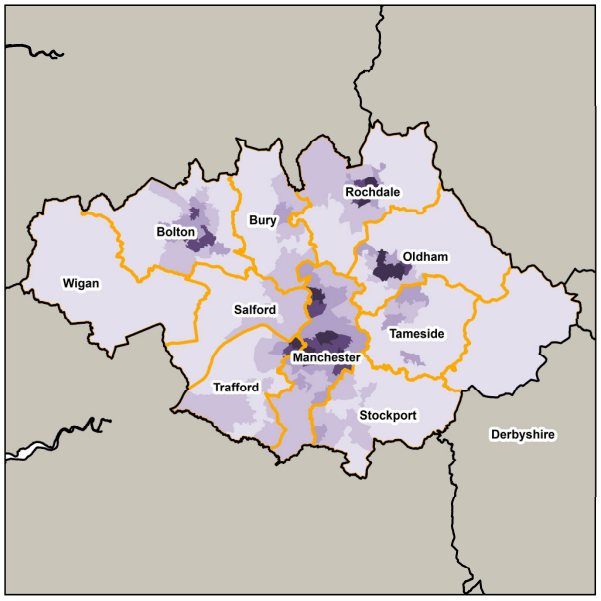
Demographic map- Age



Demographic map- Deprivation

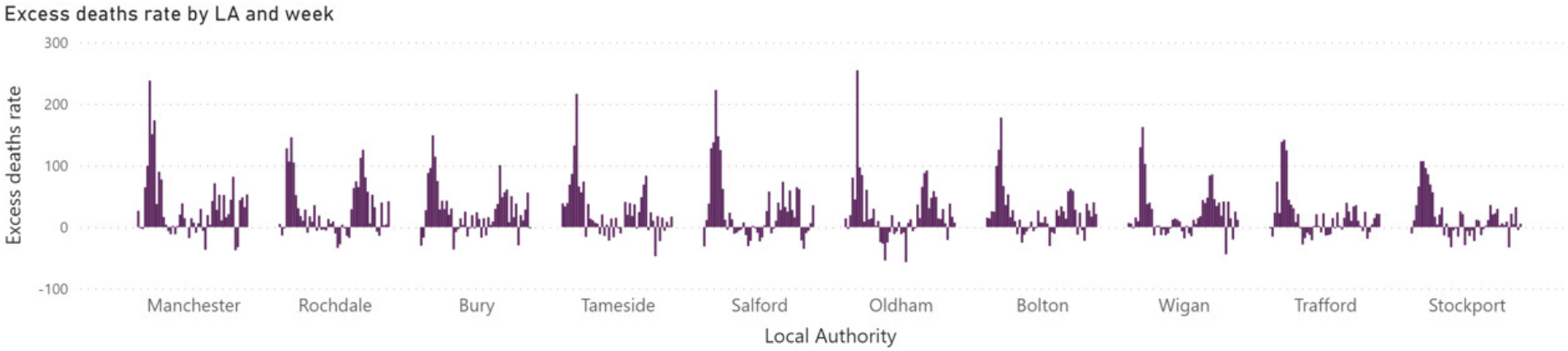


Demographic map- Ethnicity

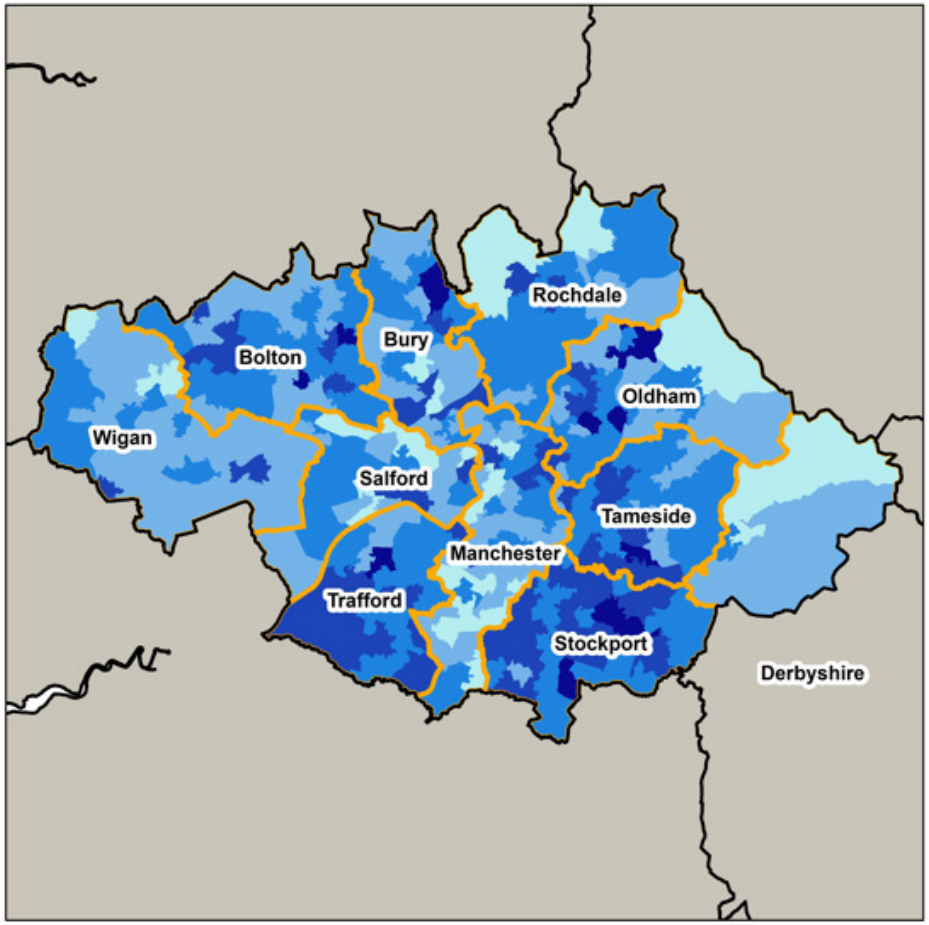


Sources: ONS- 2011; IMD- 2019; NOMIS- 2015

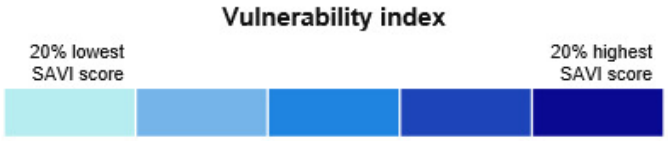
Greater Manchester in Context - mortality



Greater Manchester in Context: vulnerability



Source: PLDR, Daras and Barr, University of Liverpool- July 2018



Darker blue areas show where an area has a higher SAVI (Small Area Vulnerability Index) score. The SAVI is an empirically informed measure of COVID-19 vulnerability. The SAVI investigates the association between each predictor (proportion of BAME, care home residents, overcrowded housing and chronic health condition admission) and COVID-19 mortality. This essentially provides a measure for each area that indicates the relative increase in COVID-19 mortality risk that results from the level of each of the four vulnerability measures for each area.

There is a variation across the system in the population's vulnerability to COVID-19.
There are some pockets that have the highest level of vulnerability in Stockport, Trafford, Oldham, Bolton and Bury.

Provider Collaboration Review

Key line of enquiry findings

Key line of enquiry:

Health inequalities

- *During the pandemic, how have providers worked together to identify the **key health inequalities** in terms of cancer prevention and care?*
- *How have the **needs** of black, Asian and minority ethnic communities been addressed?*
- *Is there a shared plan or **strategic approach** to reducing inequalities?*
- *Are the voices of minorities **influencing** your work?*
- *What impact have digital ways of working had on **outcomes** for minority groups?*

Positive progress in the system – 1

What went well and why:

- GM Cancer was using data from the **GM Tableau system** and the **National Cancer Equity Data Pack** to monitor **variations in referrals by pathway** by CCG, provider and tumour sites. This included data on first treatment and referral recovery by age, ethnicity, deprivation and gender, 2-week referrals, staging of diagnosis and survival. This would allow systems to **identify variations for patient groups and demographics** to inform decision making around **tackling inequalities in cancer services.**
- **Funding had been given to specific groups**, for example LGBTQ+, learning disability and faith groups to support communities to access cancer screening services. Evidence showed more people were using screening services than had used them before, there was **an increase of 3,000 per week of patients accessing cervical screening** from 9,000 to 12,000.
- **Answer Cancer, the Greater Manchester Screening Engagement Programme provided partnership** working with four voluntary community and social enterprises. The programme worked with **different communities to look at barriers**, improve cancer awareness and increase uptake of cancer screening across GM.

Positive progress in the system – 2

What went well and why:

- Follow-up letters after FIT tests for patients with a learning disability were changed so that they had a **better understanding** of the process. The cancer improvement leads **followed up non responders** and tried to book patients into follow up diagnostic appointments.
- Data from the **mapping of vaccine hesitancy**, overlaid by black, Asian and minority ethnic population information and cancer referral data provided information on how **communities accessed cancer services, and would allow targeted interventions in the future** for example, uptake of cancer screening.
- Commissioners and primary care networks **worked with GP representatives from black, Asian and minority ethnic communities** to understand the **written and spoken language of different communities**. This identified that communities spoke in their own language and written English was better understood than translated. A **blended approach** was therefore taken to translate information
- The pandemic identified how digital could **exacerbate access problems** for some people without access to mobile internet data. This impacted on **patients accessing virtual consultations** with healthcare staff.

Areas for future focus

- There were **gaps in recording ethnicity** on GP systems (ethnicity was either not known or not recorded) which made it difficult to see the bigger picture. As part of a primary care improvement project **accurate completion of demographics** was an area being reviewed.
- Review data for **communities accessing services** and **target interventions.** To establish reasons why some **communities do not engage** with health services.

Key line of enquiry 1: people at the centre

In responding to COVID-19, how have providers collaborated to ensure that people moving through health and care cancer services have been seen safely in the right place, at the right time, by the right person?

What went well and why

- Diagnostic pathways were **standardised to allow a consistent approach** for cancer referrals across the 10 localities. The ”pandemic amplified uncertainty about prognosis for cancer patients, **clear pathways minimised this uncertainty** and provided a **support network for clinicians to work consistently’.**
- **The Surgical Cancer Hub had oversight** of the total number of cancer patients waiting for a surgical procedure across the region. The hub allowed **urgent cancer surgery to take** place at the Christie and Rochdale Infirmary, identified as green sites. This helped to **ease the pressure other acute hospitals** across GM. The number of surgical cases per week **increased from 250 pre COVID to 300 cases per week** during the pandemic.
- The cancer hub provided the **oversight and coordination function** to deliver a system wide single queue for diagnostics and treatment on behalf of the system. This approach ensured **equitable access for patients to cancer diagnostics** and enabled **system wide matching of capacity and demand.**
- Services used the **Goals of Care Initiative** from the Christie Hospital for individualised care planning. Patients could contact their healthcare team to **discuss treatment goals** and receive the information they needed.

What went well and why

- **Cancer care co-ordinators** were new **roles** developed through the cancer care programme to support patients during the pandemic. Patients across GM continued to **access the 24-hour nurse led telephone service** for advice at The Christie on the side effects caused by radiotherapy or chemotherapy and complications of their cancer treatment.
- **Prehab4Cancer and recovery programme** was an initiative developed **between Greater Manchester Active and Greater Manchester Cancer.** This was an exercise referral scheme providing exercise, nutritional support and wellbeing for people recently diagnosed with cancer. The programme was designed, **with user-involvement and in consultation with local multi-disciplinary healthcare professionals from all relevant cancer pathway boards.** During the pandemic, the programme was **adapted to virtual access** and patients could continue with pre-rehabilitation. Some patients who accessed the programme had **better physical activity outcomes** (for example walking distance) post treatment than they had before start of their treatment.
- **Hyper fractionation radiation therapy** was rolled out **quickly across the regions**, with support of GM Cancer Alliance and the Christie. This **reduced the number of patient visits** whilst still providing the same level of treatment and care, especially around treatment of tumors i.e. breast.
- GM was using the **Cytosponge** capsule. A small cohort of patients were using this as part of a pilot. This meant that **patients did not need to attend hospital**.

Areas for future focus

- Consistency of referrals for 2 week cancer waits was variable amongst primary care. This in part is due to lack of alternative pathways for GPs and during the pandemic a reduction in the face to face consultations in primary care. Inappropriate referrals may lead to pressures on diagnostic services in secondary care.
- Monitor and evaluate the impact of a blended approach to consultations, for example a mix of face to face and online consultations and the impact this has on both staff and patients.

Key line of enquiry 2: shared vision, value, governance and leadership

Was there a shared plan, value and system wide governance and leadership for cancer services during the COVID-19 period?

What went well and why

- **There was collaborative working across the system - Manchester Foundation Trust** took head and neck patients (via the surgical hub process). This ensured GM **did not have** long waits for these patients, as surgery was critical to good outcomes.
- The **system worked with the independent hospital** sector for mammography and theatre space, allowing services for **breast cancer patients** to continue.
- There was **oversight of Urgent and Emergency Care** services to ensure **flow of patients into appropriate treatment areas** allowing **prioritisation of cancer patients.**
- The development of a **26 bedded Acute Assessment Unit at the Christie** was brought forward considering COVID-19. The new units **full design and installation** was escalated and **completed in five weeks**. This enabled more rooms for patients to be managed in line with COVID-19 guidelines and **reduced the number of patients being deferred** to Emergency Departments across GM because of bed pressures.
- Dedicated diagnostic particularly endoscopy capacity for patients with suspected cancer to enable a return to pre-pandemic levels of activity. **Two rapid diagnostic treatment centres and a community diagnostic centre was developed during the pandemic** and provided **access to a rapid diagnostic pathway** for patients across Manchester and Trafford.
- A business case for **Bisphosphonates** for primary breast cancer was **expedited through working** with the Cancer Board and commissioners across GM. This enabled patients to take tablets at **home** rather than visiting the hospital for treatment.

What went well and why

- Greater Manchester Cancer Alliance **worked collaboratively** with colleagues from the cancer system to ensure there was a **co-ordinated approach to monitoring harm** caused by long waits in the pandemic. **Harm reviews** from across the city have been **collated at system level** to ensure themes can be established, and to gain visibility over pathways that span multiple organisation. A process for the communication of harms and for **shared learning** was in place.
- The GM **Endoscopy Clinical Reference Group** started looking at waiting times in July 2020 to improve **patient flow which was limited because of COVID restrictions**. Funds were agreed to provide **two additional endoscopy rooms**. All **trusts and primary care leads came together** and looked at where the biggest patient need was, in terms of **priority access**. This happened quickly from concept to **implementation in less than 3 months** and **reduced waiting times**, from 25 weeks in July 2020 to 11-12 weeks in April 2021.
- Care homes across Salford worked with GPs and end of life facilitators to review all DNACPRs, so forms **reflected personalised** recommendations for a person's clinical care and treatment and correctly followed guidance.
- The system worked with adult social care providers to **support staffing and PPE**. ASC were **part of the community cell** which enabled **information to be shared** about planned activity, what services were stepped down and what services could be delivered across GM.

Areas for future focus

- **Delivery on the backlog clearance plan**, due to the high volumes of patients waiting over 62 days during the pandemic.
- **Monitor the potential impact of patients presenting with concerning symptoms at a later stage.** For example, suspected lung cancer referrals have significantly reduced probably due to the overlap of symptoms between COVID and lung cancer and the decline in the levels of screening uptake.

Key line of enquiry 3: workforce capacity and capability

Was there a strategy for ensuring the safety of staff, and sufficient skills of staff working in cancer services across the health and care interface?

What went well and why 1

- The **workforce cancer steering group** developed a **cancer workforce strategy for the next 5 years** which supported the recovery plan post pandemic.
- Providers across the system reviewed their nursing numbers, additional clinical skills and availability of nurses to **work differently**. Nurses with critical care skills received refresher training and were placed on a **shadow rota to be redeployed into clinical services.**.
- The Christie used COVID-19 funds to employ additional **clinical fellows** which enabled more **senior cover** on the wards. **Physician associates** were used across cancer pathways working closely with cancer nurse specialists.
- Oncology registrars were taken from their outpatient duties and **redeployed to provide support on the wards.** Palliative care staff **helped in critical care and high dependency units**, providing peer support, debriefing sessions, shared learning and clinical input.
- Directors of nursing **worked with universities** in GM to employ **aspirant nurses** to work in the hospitals to provide support when there were staffing shortages due to COVID 19. **Fifteen aspirant nurses** in their final months of training supported the Christie.
- Staff well being was **important. Increased communication, access to counselling support services and complimentary therapies were available**. At the Christie **free vitamin D** was given to staff who wanted it. Care homes had **access to funding** to enable them to pay staff should they **need to self-isolate**, to minimise risk of COVID-19 within care homes.

What went well and why – Gold standard bio security measures.

- Providers took a **pragmatic approach to PPE**. Stock of PPE was reported at the **daily executive situation report meetings**. Changes to PHE guidance was **monitored by the infection control teams** and the **COVID-19 incident room**.
- **The gold standard bio security and IPC system established at the beginning of the pandemic had proved effective**. We were informed that the 'safe surgery' audit carried out of over 10,000 patients showed less than 1% pre-op COVID positive cases, the audit was an excellent tool to evidence the provision of safe cancer surgery and a signal that bio-security measures were working. **We were told that during the last year, GM had carried out cancer surgery than in the last 2 previous years**.

Areas for future focus

- **Staffing capacity** will continue to be a challenge across the system, this is compounded by the impact of COVID exhaustion which need to be considered in the post recovery plan such as future proof teams to manage post pandemic clinical activity.
- **Review processes** in hospices where delivery of medicines where services may be disrupted. For example, outsourcing products commercially and the use of community pharmacies and dispensaries.

Key line of enquiry 4: digital solutions and technology

What impact have digital solutions and technology had on providers of cancer services during the COVID-19 period?

What went well and why

- The **Cancer Digital Transformation Board** linked to GM wider **Digital Transformation Board. There were existing** governance structures pre pandemic closely linked to Health Innovation Manchester. The GOLD command structures strengthened oversight of digital solutions across all providers.
- Reliable data streams through **GM Tableau system allowed effective delivery and monitoring of cancer services.** This meant that patients could be moved across GM for treatment and diagnostics which provided a new way of working due to the pandemic.
- Daily situation reports allowed **decisions to be made by primary, secondary and community services at pace** across GM.
- Technology services were **implemented quickly** to support clinical services. Examples were on-line multi-disciplinary care meetings, stratified follow up appointments for patients and virtual clinics with a pharmacist for patients starting chemotherapy treatment.
- **Performance, recovery and planning tools** helped drive decision making and allowed early intervention for patients to access services.
- **GM PACs** project allowed radiologists to move over to a **single instance of diagnostic imaging** across GM. Consultants could **work from home to** review scans which meant there was continuation of patient care.
- Meetings for service users were **held virtually enabling different people to be brought together** '*this had saved time with travel and increased service user engagement.*

Areas for future focus

- **Monitor and evaluate the impact** of a blended approach to consultations and communicating with patients and their relatives, for example the impact of delivering bad news remotely and on the quality of palliative care.
- The pandemic highlighted the **digital inequalities across communities** within Greater Manchester, for example, patients unable to access emails communication, have access to mobile device or unable to participate in virtual consultations.
- There was **limited data and targets for metastatic pathways**, which meant less knowledge and information about **secondary cancer.**

Medicines Optimisation feedback

- Pharmacy services **worked together to provide person-centred care** for cancer patients. Medicines were managed to ensure **stocks were sufficient.** Chemotherapy pathways were reviewed, and changes were made to **reduce the need for acute hospital attendance.** Delivery services were put in place and outreach or at home locations were used for administration.
- ***Outreach and peripheral sites across GM*** were utilised for face-to-face appointments, including GP practices. **The Christie At Home service** administered immunotherapy in patients homes where possible. Patients were **switched to oral or s/c treatments** to **reduce the need for hospital attendance** on an individual patient by patient decision. **Treatment break procedures** were changed to allow patients to stop and restart as needed.
- GM pharmacists **worked with NHSE and NICE** to create covid guidance for anticancer treatments that were adopted nationally. An **End-of-Life formulary** was adapted to account for possible medicine shortages. **All GM pharmacists were invited to systemwide meetings** to identify issues and find solutions, including staffing, infection rates and mutual aid needs. Cancer networks continued to meet throughout the pandemic.
- There was little **redeployment from cancer services** and staff **work patterns were adapted** and additional training provided **to ensure optimal cover**. Mutual aid across hospital trusts and **outsourcing of medicines** where necessary meant **pharmacy services were maintained.** Additional demand and staff shortages have taken its toll and pharmacy staff are exhausted.
- **Fully integrated IT systems** meant prescribing, dispensing and administering medicines **took place seamlessly**. Care records were **available to all healthcare providers across the system**, so remote working and **administration in the home was possible**, which meant patients were safer and reduced hospital footfall.

Oral Health feedback

Please note: We were only able to speak to staff in restorative dentistry. These individuals could not answer questions relating to the waiting and diagnosis times or initial treatment and surgery for oral cancer.

- The Peter Mount Building (on the Central Manchester site) was **well organised for patient access** and to enabled staff to **effectively manage the movement of patients** on site. Staff **received positive feedback** from patients who felt safe and happy to attend there. Staff report that post aerosol generating procedure **down time remained a challenge** as this is still 1 hour which reduces capacity.
- Covid-19 resulted in multi-disciplinary meeting participation being **initially reduced** as per national British Association of Head & Neck Oncologists guidance to only include cancer surgeons, oncologists and radiologists. The restorative **team's participation resumed once virtual meetings** were in place. Patient numbers going through MDT were **almost back to pre-pandemic levels**.
- The restorative team were **not able to see patients face to face** until much later, they **worked collaboratively** with The Christie to ensure patients had dental radiographs taken there as **part of their radiotherapy planning**. The restorative dentists had **good access to the system** to view these images and discuss them with patients prior to the first face to face meeting which took place as soon as possible. This had significantly **increased the administrative work burden on staff.**
- During the period when dental services were closed, it was **very challenging to ensure patients had diseased teeth removed** before they started radiotherapy treatment. Access to **elective general anaesthetic services** was a **significant challenge**. Reconstructive surgery was **delayed due to capacity and backlog**. The team kept in frequent contact with patients for any issues and to manage expectations.
- The dental hospital experienced **significant IT challenges**. Computers were **not equipped with cameras** and staff could **not connect to Wi-Fi**. This resulted in them **using their own equipment** to connect with translation services and to attend meetings.
- Many members of the **dental team were redeployed**. The pandemic had also **significantly impacted** the **progression of trainees**. Specialty trainees were **proactive and arranged an educational timetable** and clinical teaching for core and junior trainees.

Our review of patient notes

Feedback from remote clinical access to 47 x GP care records - key findings

- Patients referred by fast track or 2 week wait for suspicion of cancer reported symptoms by phone and not examined face to face – for example for breast cancer, lower GI.
- Patients receiving a cancer care review since diagnosis was variable.
- Cancer diagnosis was discussed but not always coded.
- Not all patients had a cancer care plan.
- Not all patients were informed to contact the provider if they'd not received an appointment to be seen in 2 weeks this meant patients may not be followed up.
- From the sample of records reviewed there was no evidence of delays in referrals being made or potential patient harm.

Please note this is a small sample size of 47 records and therefore not reflective of the wider GM area.

Examples of positive practice and learning

Examples of positive practice & learning

- There was strong evidence of a **single system approach** which helped ensure cancer services **remained a priority during the pandemic**. This was largely the outcome of successful formal governance structures that had evolved during the development of the Greater Manchester Health and Social Care Partnership prior to the pandemic. **"Existing integrated structures for cancer enabled effective transaction and execution of system working during the pandemic.**
- Greater Manchester Health and Social Care Network and the Cancer Alliance ensured that systems and services were maintained and innovation and research continued throughout the pandemic, for example, the cancer MDTs ran to the **same frequency** (weekly or more) and using the **same operational policies** throughout the pandemic.
- The system prioritised cancer care at the beginning of the pandemic and they rapidly rolled out IPC measure and gold standard bio security measure were put in place to maintain patient safety and access to treatment, for example:
  - A **risk stratification process** for **adult patients with suspected or diagnosed cancer during the COVID-19 pandemic** was developed**.**
  - **Pathways and expert advise were available when national information was released.** This enabled cancer patients to be seen and treated safely following **evidence-based guidelines**.
- **The system worked on a recovery plan for cancer services** which was developed in June 2020 and approved through the GM Cell structure, with the **GM Cancer Alliance playing a key role** in cancer service delivery and recovery.

Reflections – 1

- There was strong, consistent and well organised leadership throughout the GM Cancer System.
- Great Manchester Health and Social Care Network have cancer Services throughout.
- The Cancer Alliance were instrumental in leading the work in GM during the pandemic, this enabled the system to mobilise quickly and decisions could be made at pace.
- Guidance was available across all services, so that people involved in cancer care had the necessary information to deliver safe and effective care.

Your questions please

Provider Collaboration Review

Feedback from Greater Manchester ICS to local findings

Greater Manchester feedback to local findings – Health Inequalities

How do you respond to these local findings?

Greater Manchester feedback to local findings – Key line of enquiry 1 (People)

How do you respond to these local findings?

Greater Manchester feedback to local findings – Key line of enquiry 2 (Shared plan and leadership)

How do you respond to these local findings?

Greater Manchester feedback to local findings – Key line of enquiry 3 (Workforce)

How do you respond to these local findings?

Greater Manchester feedback to local findings – Key line of enquiry 4 (Digital)

How do you respond to these local findings?

Early Diagnosis Steering Group

Title of the paper:	Early Diagnosis: September 2021 summary update to GM Cancer Board
Purpose of the paper:	To provide the GM Cancer Board with an update on the work of the Early Diagnosis Steering Group
Summary / outline of main points / highlights / issues:	• Background & Introduction • Early Diagnosis progress to date • Early Diagnosis workplan and objectives (April 21 – March 2022)
Consulted:	Early Diagnosis Steering Group
Author of paper and contact details:	**Name:** Rebecca Martin **Title:** Project Manager, Early Diagnosis, Commissioning & Primary Care **Email:** Rebecca.martin30@nhs.net **Presented by:** Alison Jones **Title:** (Interim) Director of Commissioning **Email:** Alison.Jones8@nhs.net **Name:** Dr Sarah Taylor **Title:** GP Cancer Early Diagnosis Lead for Greater Manchester **Email:** sltaylor@nhs.net

1. Background & Introduction

In April 2021 a proposal was submitted to the Greater Manchester Cancer Board to establish an Early Diagnosis Steering Group to lead a programme of work on behalf of the GM Cancer Alliance and the GM system to achieve the national Long Term Plan target of 75% of cancers diagnosed at stage 1 or stage 2 by 2028.

The Early Diagnosis Steering Group has been established as part of the GM Cancer Alliance governance structure, thus reporting to and held to account by the Greater Manchester Cancer Board. This paper intends to describe the progress of the Early Diagnosis Steering Group to date and to outline the proposed programme of work and priorities for 2021/22.

2. Early Diagnosis – Progress to Date

In May 2021 the GM Cancer Alliance submitted a response to the national planning guidance outlining how the £4.46 System Development Funding would be allocated, £495k of which was allocated to support early diagnosis and the delivery of the national Long Term Plan ambition to diagnose 75% of cancers at stage 1 or 2 by 2028.

The Early Diagnosis Steering Group has recently supported proposals for the use of the additional funding as described below and summarised in the document at **Appendix 1.**

Through the ongoing engagement with Clinical Commissioning Groups, Primary Care Networks and the GM Primary Care Cell / GP Board, there has been a sustained focus on early diagnosis, effective referral processes and patient / public / professional facing communications throughout 2020-21/22. The information below summarises some of the key pieces of work.

a. Public and Patient Facing Communications

Further work is progressing with GM Cancer communications colleagues to develop a GM patient and professional programme of communications to support an increase in the number of people coming forward and being appropriately referred with symptoms suspicious of cancer. This will further support the Cancer Alliance and GM system recovery by ensuring messages are targeted to communities and geographies where need is greatest.

Below are the initial priorities that have been identified from a pathway, geographical and patient perspective:

Pathway(s):

- Lung
- Urology (particular focus on prostate)
- Lower GI (to include public facing message on the use of FIT testing)

Geography

Communication materials will be available to all 10 localities but there are continued lower levels of referrals (not recovered to pre-covid status) in the following areas in GM:

- Wigan
- Stockport
- Heywood, Middleton and Rochdale (HMR)

Patient Groups

- Gender (referrals for females have recovered more than referrals for men)
- Age (impact on the older age groups when looking at recovery of referrals)
- BAME population – it will also be necessary to ensure that any information that is produced is available in languages other than English. This will include working with AskDoc to support the design of resources and videos

b. Primary Care Network (PCN) Engagement

Following conversations with GM PCN Clinical Leads, GP Board and further discussions with Primary Care Cell members and the GM Primary Care Provider Board Managing Director, the Early Diagnosis Steering Group received and approved a proposal to allocate £3,000 to each PCN in GM. The GM Cancer Alliance has proposed that each of the 67 PCNs in Greater Manchester are asked to nominate a cancer lead for their PCN. This role could be an administrative, management or clinical member of staff who would be the first point of contact for the GM Cancer Alliance, to discuss and disseminate new pathway developments and initiatives and who will be the 'champion' for cancer for their PCN.

Attached at **Appendix 2** is the detail of the proposal agreed with GM PCNs. At the time of writing this paper 16 PCNs have confirmed the details of the Cancer Lead and 2 drop in sessions have been arranged with them all for the 5th October 2021.

c. Gateway C

Four GatewayC GM Live Webinars have been delivered by the GM Cancer Team in line with the request and steer from the Primary Care Cell and GP Board members to offer shorter and more succinct webinars on topics relating to cancer pathways in GM. Webinars delivered to date are: Lower GI; Lung; Prostate and Upper GI. Each GM webinar is followed up with a full length recording, a shorter and illustrated/animated version of the video, and an infographic summarising the key points from the webinar.

Attached at **Appendix 3** is the material that has been produced following the webinars.

The Early Diagnosis Steering Group recently supported allocation of funding to a further series of webinars to run on a monthly basis from September 2021. Following discussions with CCG, Alliance and provider contacts, the following schedule is proposed:

September 2021	Skin
October 2021	Breast
November 2021	HPB
December 2021	Session on all cancers specifically designed for Healthcare Assistants and Primary Care administrative staff
January 2022	Head & Neck (to include dental colleagues in the audience as key referrers onto this pathway)
February 2022	Non-site specific / Rapid Diagnostic Centre pathways
March 2022	Gynaecology (with a specific focus on ovarian cancer)

The Cancer Alliance and Gateway C team are working together to enhance the marketing and promotion of the webinars and the material produced following the webinars.

d. GP System Projects (Digital Solutions)

The GM Cancer Alliance Breast Pathway Board has produced algorithms to support decision making in primary care ahead of a 2WW referral. Further work is ongoing with GM Shared Services to make this information available on GP systems – initially to be tested in Manchester, Oldham and Stockport CCGs before roll out to all localities. This will be available for all GP systems, not just EMIS.

Work is ongoing to link the work outlined above in relation to the GatewayC webinar infographics to GP systems, the infographic will further support work on decision making tools that GMSS are progressing.

Conversations are also progressing with Health Innovation Manchester to further explore the opportunities for digital support to the early diagnosis and referral management work.

e. Referral Management

The GM Cancer Team continue to focus on referral management with a particular focus on pathways where there are reported challenges with the achievement of the 2ww standard and where there is an increased level of demand.

In January 2021 enhancements were made to the Advice & Guidance functionality on eRS which mean a referrer (GP) can authorise a consultant to convert a request for Advice & Guidance into a referral if appropriate and if sufficient information is provided. This will ensure the patient can be efficiently referred into the appropriate service without delay.

A pilot in Tameside & Glossop CCG to support improvements in the 2ww referral process for head & neck referrals launched on the 4th May 2021. The pilot will monitor the impact of eRS Advice & Guidance functionality for patients who do not meet the suspected referral criteria but where prompt specialist input is required, for example:

- Patients who have previously been investigated for similar symptoms
- Uncertainty about the initial referral pathway or for enquiries regarding an on-going treatment plan or investigations

The consultant is then able to send back advice to the GP as requested, request further information, or convert into a referral (2ww or routine).

All GM Suspected Cancer referral forms are due to be reviewed in September 2021 in line with the most up to date NICE Guidance (NG12) and with the input of the Pathway Board Clinical Leads. The GM Cancer Team will continue to work with CCGs and Providers in GM to review the uptake and use of these forms, identifying any areas where forms are not routinely being used and/or completed.

3. Next Steps / Programme Priorities for 2021-22

Attached at **Appendix 4** is the work plan for the Early Diagnosis Steering Group for 2021-22

4. Recommendations

Cancer Board is asked to:

- Note and offer comment on the content of this report
- Support the proposed Early Diagnosis work plan for 2021/22

Appendices:

Appendix 1: Financial Summary

Appendix 2: PCN Proposal

Appendix 3: GatewayC Live GM Webinar Material

Appendix 4: Early Diagnosis Work Plan for 2021-22

Appendix 1: Financial Summary

GM Cancer Alliance: Planning Guidance Response 2021-22 - Early I

Deliverable	Summary of 2021/22 system plans, including any additional Alliance-led activitie Please include a **high level** summary of the relevant deliverables from your system/Allia appropriate.
Cancer Alliances should ensure a continued focus on delivery of the LTP objectives which support achievement of the early diagnosis ambition	GM Cancer Alliance have established an Early Diagnosis Steering Group reporting directly to the GM Cancer Board. delivery of initiatives to support achievement of the national LTP ambition of achieving 75% Stage 1 or 2 diagnosis b projects to support recovery and restoration. Resource to support this work and achievement of the LTP ambition wil - Development of a GM patient and professional facing programme of communications to support an increase in the and included in the resource requirement above - Recovery) - Co-ordination and engagement to support Early Diagnosis Steering Group priorities and engagement with locailties - GP Referral - Practice and PCN based patient Communication (including text messaging and addressing areas an - Development of processes to support effective referral management between primary and secondary care, includir pathways and processes in place to support this, including the development, implementation and review of standarc - Community and VCSE engagement - GP education Webinars and social media messaging - Cancer protocol development and communication / links with GP systems - Work across Primary Care on cancer referral pathways, including dental provider engagement for Head & Neck car
Communication	Development of a GM patient and professional facing programme of communications to support an increase in the r referred and at a level to meet expected treatment levels by March 2022. Supports Cancer Alliance and GM system r by ensuring messages are targeted to communities and geographies where need is greatest*
Primary Care Liaison / PCN DES and QOF	GM Cancer will allocate £3,000 to each PCN in return for the identification of a PCN Cancer Champion and engagem actions during 2021-22 to support early diagnosis of cancer and delivery of the PCN DES. The Cancer Alliance will p materials, education resources and in addition to the CCG cancer commissioning managers will be a point of contac diagnosis cancer pathways.

Appendix 2: PCN Proposal

GM Cancer: Primary Care Networks & Early Diagnosis

2021-22 Funding Proposal

Context

Primary Care has played a crucial role in maintaining and expanding general practice throughout the COVID-19 pandemic, to meet the continued needs of patients and communities. However, as a result of the pandemic we have seen an overall reduction in the number of people being referred urgently with suspected cancer, and being referred from cancer screening programmes. Although we haven't seen the sharp reduction in referrals we saw at the start of the pandemic, referrals for some cancers remain challenged – in particular on the lung and urological pathways. Since March 2019 around 37,000 fewer people started treatment for cancer than we would have expected. Identifying, diagnosing and treating these people will be a priority in 2021/22.

GPs and PCNs will continue to play a critical role in supporting the identification and rapid onward referral of patients who we would have expected to start cancer treatment but who are yet to do so, including through delivery of the PCN DES. Cancer Alliances have been instructed by the National Cancer Programme to work with PCNs to support delivery of the DES and cancer recovery.

Proposal

The GM Cancer Alliance propose that each of the 67 PCNs in Greater Manchester are asked to nominate a cancer lead for their PCN. This role could be and administrative, management or clinical member of staff who would be the first point of contact for the GM Cancer Alliance, to discuss and disseminate new pathway developments and initiatives and who will be the 'champion' for cancer for their PCN.

Early diagnosis

This funding is not based on delivery of all the actions below, but suggested improvement areas include:

- Ensure practices within the PCN refer using GM forms
- Ensure patients are told of reason for referral – work with Alliance colleagues where needed to access patient information leaflets etc.
- Use appropriate safety netting systems for symptoms, investigations and referrals

- Ensure patients are referred to appropriate clinics (including Rapid Diagnostic Centres where appropriate to the PCN – not currently GM wide)
- Use the correct SNOWMED code for referrals for suspected cancer to support robust safety netting records
- Consider ways of encouraging patients to attend with concerning symptoms and work with the Cancer Alliance to design, develop and deliver PCN / GM level support
- Disseminate cancer related information to practices with in the PCN and encourage participation in GM delivered GP / Primary Care education
- Engage in the design of GP / Primary Care education funded and delivered via GM Cancer
- Review new cancer diagnoses, consider learning events in all patients who have been diagnosed following emergency admission and routine referral

Screening

- Encourage and support coding of screening results including non-responders
- Contact non-responders – inform the design of materials to do so, including text messaging and online materials (funded and delivered via GM Cancer)
- Consider ways to engage patients who are not responding to invitations
- Prioritise patients who failed to respond to f/u for positive FIT

Funding

GM Cancer will allocate £3,000 to each PCN in return for the identification of a PCN Cancer Champion and engagement in delivery of the above actions during 2021-22. The Cancer Alliance will provide further support in the form of all communication materials, education resources and in addition to the CCG cancer commissioning managers will be a point of contact for PCNs for any queries or issues relating to early diagnosis cancer pathways.

Dr Sarah Taylor

Alison Jones

Appendix 3: GatewayC Live GM Webinar Material

Gateway C GM Live Webinars

Four **Gateway C GM Live Webinars** have been delivered by the Cancer Alliance in line with the request and steer from primary care and GP Board members to offer shorter and more succinct webinars on topics relating to pathways in GM. Webinars delivered to date are listed below with links to the resources available.

Each GM webinar is promoted widely in advance and is followed up with a full length recording, a shorter and illustrated/animated version of the video, and an infographic summarising the key points from the webinar. The link to the Gateway C website is here with specific links below https://www.gatewayc.org.uk/free-webinars-gm/

The 4 infographics produced to date can be seen below. Please do access the resources below, share with colleagues and look out for details of future webinars starting in September with a skin pathway session – details to follow!

Lower GI: https://youtu.be/jdSqR5TSet0 (short version) or
https://courses.gatewayc.org.uk/mod/page/view.php?id=5598 (full webinar)
.
Lung: https://www.youtube.com/watch?v=iF2lTjQyTuE (short version) or
https://courses.gatewayc.org.uk/mod/page/view.php?id=5835 (full webinar)
.
Prostate: https://www.youtube.com/watch?v=C7ZfZPWTS2w (short version) or
https://courses.gatewayc.org.uk/mod/page/view.php?id=6027 (full webinar)

Upper GI: https://youtu.be/M_GZAJqKkbo (short version) or
https://courses.gatewayc.org.uk/mod/page/view.php?id=6037 (full webinar)

LOWER GI CANCERS
THINK A-G

Supporting earlier & faster cancer diagnosis

GatewayC LIVE Greater Manchester

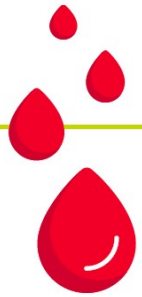
FAST FACTS

A — ANY CHANGE IN BOWEL HABIT OR UNEXPLAINED SYMPTOMS?

Check for any change in bowel habit, either diarrhoea or constipation, which persists or other associated symptoms including: abdominal pain, abdominal/rectal mass, unexplained weight loss, or anaemia. Be aware of symptoms in both older and younger patients.

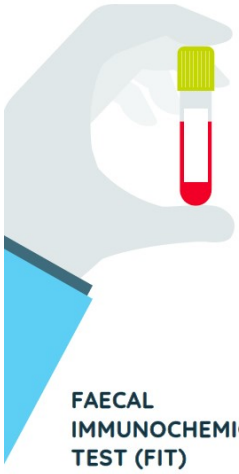
B — BLEEDING

If patients report rectal bleeding, whether it is bright red blood noticed in the toilet or stools containing altered blood, it is important to investigate this.



C — CHECK BLOODS

Anaemia, raised platelets or abnormal liver function increase the suspicion of lower GI cancer, but normal results do not exclude it. It is important to check specifically for iron-deficiency anaemia and include renal function to enable the patient to have a colonoscopy.



D — DON'T FORGET FAMILY HISTORY

If a patient has a family history of cancer or polyps this will raise the index of suspicion.

E — EXAMINATION

Examine the abdomen and rectum. If you notice an abdominal or rectal mass this should raise suspicion.

F — FAECAL IMMUNOCHEMICAL TEST (FIT)

- FIT should be used to assess the need for referral in low-risk patients (see guidelines)
- FIT should be sent with high-risk referrals to aid prioritisation in secondary care (secondary care practitioners will deal with these results)
- Remember cut-offs used in FIT screening are higher, therefore a negative screening test should not be used to assess a symptomatic patient

G — GREATER MANCHESTER REFERRAL PROFORMA

- Please refer all patients using the Greater Manchester form
- Ensure the patient understands the reason for referral
- Include frailty information as this helps direct patients to the most appropriate investigation or assessment

REFERRAL PROCESS FOR GREATER MCR

GM referral form

Bloods

FIT value

Online cancer education for healthcare professionals
Register here: www.gatewayc.org.uk/register

GMCA Greater Manchester Combined Authority · NHS in Greater Manchester · Greater Manchester Cancer

LUNG CANCER
THINK A-G

Supporting earlier & faster cancer diagnosis

GatewayC LIVE Greater Manchester

FAST FACTS

A — APPETITE LOSS

Reduced appetite, lethargy or weight loss can be presenting symptoms of lung cancer. Consider a chest X-ray (CXR), CT scan or referral to a non-site specific clinic.

B — BLOOD TESTS

Abnormal blood test results (i.e. anaemia, raised platelets, raised white cell count low albumin, and/or ferritin) may trigger a suspicion of lung cancer. Investigate further with a CXR and consider a referral on the suspected lung cancer pathway for a CT scan, even if the CXR is normal.

C — COUGH

Any cough lasting 3 weeks or more (or breathlessness/chest pain) should trigger a CXR. If any concern of lung cancer remains despite a normal CXR, then refer on the suspected cancer pathway.

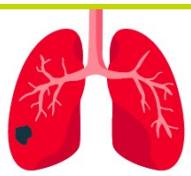
REMEMBER: Not every cough is Covid.

D — DON'T FORGET NEVER-SMOKERS

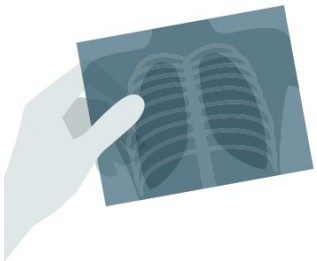
A never-smoker is defined as someone who has smoked less than 100 cigarettes in their lifetime. Approximately 6000 people that are never-smokers die of lung cancer each year in the UK; this is the 8th commonest cause of cancer-related death. Always investigate patients with persistent chest symptoms.

E — EARLY DIAGNOSIS

The early diagnosis of lung cancer improves prognosis. It's important to investigate patients with persistent respiratory symptoms such as, breathlessness, chest pain and haemoptysis.



F — FALSE NEGATIVE RATE OF CHEST X-RAYS



25% of lung cancers are not visible on chest X-rays. A normal CXR does not exclude lung cancer. If any concern of lung cancer remains despite a normal CXR, refer for a CT scan or on the suspected lung cancer pathway.

G — GREATER MANCHESTER REFERRAL PROFORMA

- Please refer all patients using the Greater Manchester form
- Ensure the patient understands the reason for referral
- Include frailty information as this helps direct patients to the most appropriate investigation or assessment

REFERRAL PROCESS FOR GREATER MCR

GM referral form

Bloods

Recent CXR results

Online cancer education for healthcare professionals
Register here: www.gatewayc.org.uk/register

GMCA Greater Manchester Combined Authority

NHS in Greater Manchester

Greater Manchester Cancer

PROSTATE CANCER
THINK A-G

Supporting earlier & faster cancer diagnosis

GatewayC LIVE Greater Manchester

FAST FACTS

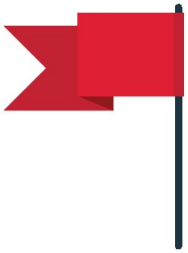
A — AGE-SPECIFIC PSA

If the prostate-specific antigen (PSA) level is above the age specific range, refer urgently using a suspected cancer referral form for an appointment in two weeks. Clinical judgement should be used to manage symptomatic men and those aged under 50 who are considered to have a higher risk or prostate cancer.

B — BAME GROUPS

The incidence of prostate cancer is higher in black males. 1 in 4 black men will get prostate cancer and they have a worse prognosis.

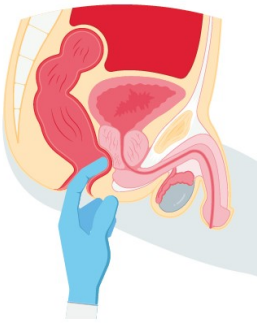
C — CONSIDER RED FLAG SYMPTOMS



Symptoms of metastatic disease include: sudden onset urinary incontinence, faecal incontinence and loss of power in the lower limbs. These are an emergency presentation and can indicate metastatic spinal cord compression and require immediate admission to hospital.

D — DIGITAL RECTAL EXAMINATION

If the prostate feels irregular or craggy on examination refer on a suspected cancer pathway regardless of the PSA result.



E — EXCLUDE URINARY TRACT INFECTIONS

Urinary tract infections can falsely elevate a patient's PSA level. If a PSA level is marginally elevated then recheck 6 weeks after treating the UTI before referring.

F — FAMILY HISTORY

Family history of prostate, breast cancer or ovarian cancer increases risk of prostate cancer. It is important to ask about family history when assessing prostatic symptoms or considering a PSA test.

G — GREATER MANCHESTER REFERRAL PROFORMA

- Please refer all patients using the Greater Manchester form
- Ensure the patient understands the reason for referral
- Include frailty information as this helps direct patients to the most appropriate investigation or assessment

REFERRAL PROCESS FOR GREATER MCR

GM referral form

DRE

MRI scan

Biopsy

(if appropriate)

Online cancer education for healthcare professionals

Register here: www.gatewayc.org.uk/register

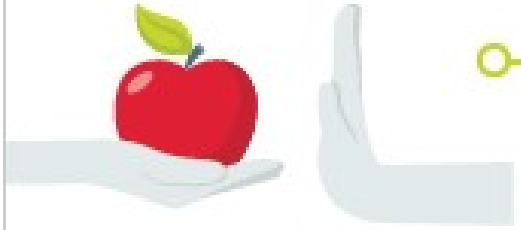
GMCA Greater Manchester Combined Authority

NHS in Greater Manchester

Greater Manchester Cancer

UPPER GI
THINK A-G

Supporting earlier & faster cancer diagnosis



A

B

APPETITE LOSS

Appetite loss, fatigue, nausea, and weight loss can all be presenting symptoms of upper GI cancers.

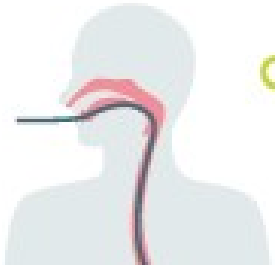
C

CHECK BLOODS

Anaemia or raised platelets increase the suspicion of upper GI cancers; however, a normal full blood count does not exclude it. It is important to check specifically for iron-deficiency and B12 deficiency as this can trigger a different approach for the endoscopist.

D

DYS



E

ENDOSCOPY

An endoscopy is the first line of investigation for suspected malignancy and is the most accurate

Appendix 4: Early Diagnosis Work Plan for 2021/22

GM Cancer Early Diagnosis Steering Group - Work Programme 2021 (Apr21-Mar22)

Strategic Objective:	By 2028, 75% of people will be diagnosed at an early stage (stage 1 or 2)					
Area of work	**Deliverable**	**Measure - SMART**	**Responsibility**	**To be completed by**	**RAG Status at July 2021**	**Comments**
Referral Management	Develop processes to support effective referral management between primary and secondary care, including 'Advice & Guidance'	Review data / impact following pilot in T&G	ST / RM	Sep-21		A&G pilot to support 2ww referral process in head & neck went live on the 4th May - further communications required to promote the use of A&G and the new functionality available on eRS.
	Embedding NICE Referral Guideline NG12 and ensuring pathways and processes in place to support this, including the development, implementation and review of standardised referral forms	2ww Referral form standardisation & review	Via CCMs / Trust Cancer Managers Via the GM Pathway Boards	Sep-21		
	Monitor ongoing impact on referral patterns from Primary Care	Providing feedback to pathway boards	ST / AJ / RM	Mar-22		
	Digital Solutions	GatewayC infographics to be made available on all GP systems to support decision making Breast algorithms for breast pain and nipple discharge to be made available on all GP systems	RM / GMSS	TBC		Initial conversation with GMSS (Thomas Power) to progress.

Diagnostic Pathways	Rapid Diagnostic Centre and Community Diagnostic Centre Developments; explore options for direct patient access diagnostics; continued Targeted Lung Health Checks implementation	Continued Targeted Lung Health Checks implementation				
		Direct Access Chest X-Rays - AZ Project	Lung Pathway Board			
		RDC development - ensure full population coverage of RDCs by 31/03/2024 - ensuring alignment with CDHs Ensure aligment with CDHs	SS / ST	Mar-24		
Primary Care Education	Extend range of Gateway C GM Live Webinars to cover additional pathways: accessible education for primary care	GatewayC LIVE Webinars	ST / AJ / RM	Mar-22		Funding to support an additional 7 webinars from September 2021 - March 2022
Patient / Public / Professional Communications	Continue to deliver national messages encouraging patients to present with symptoms of cancer AND new approaches using the GM place-based system connections beyond 'NHS'; build on collaboration between H&SC in GM	To develop a range of materials to support engagement / earlier cancer diagnosis from a pathway specific; geographical and patient group perspective.	ST / AJ / RM Via AP / AF (Communications)	Mar-22		AP update at the ED Steering Group on 24/08
Primary Care Networks	Support to Primary Care and Primary Care Networks for delivery of core contractual, QOF and DES requirements	Each of the 67 PCNs in Greater Manchester are asked to nominate a cancer lead for their PCN who will be the 'champion' for cancer for their PCN	ST / AJ / RM JCG (GP Board)	Sep-21		Proposal to allocate £3,000 to each PCN in GM approved. Janet Castrogiovanni has agreed to communicate this to PCNs and is working with the Cancer Alliance on the transaction of the funding and setting up the necessary processes and communication routes

Health Inequalities	Ensure support is targeted where need is identified as being greatest and address inequalities by population, geography and pathway	Develop an Early Diagnosis Dashboard to build on previous GM Cancer 'Metrics'	AJ / RM / PG	Mar-22		
General	Early Diagnosis Terms of Reference		AJ / RM	Mar-21		Live document to be updated as appropriate

END OF REPORT

Greater Manchester and East Cheshire Cancer Workforce Strategy Implementation Plan

Title of paper:	**Greater Manchester and East Cheshire Cancer Workforce Strategy Implementation Plan**
Purpose of the paper:	The Greater Manchester and East Cheshire Cancer Workforce Strategy was presented and ratified by the Cancer Board in April 2021. The following paper details planned activity over the next 5 years to support implementation of the strategy.
Summary outline of main points / highlights / issues	The key discussion points in this document are: • Implementation plans for all key professional groups involved in the delivery of cancer care • Risks and mitigating actions
Consulted	Greater Manchester Cancer Workforce Steering Group chaired by Dave Shackley, Director for GM Cancer Alliance. Cancer workforce steering group and subgroups.
Authors of paper and contact details	**Name:** Suzanne Lilley **Title:** Cancer Workforce Lead **Email:** suzanne.lilley2@nhs.net

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Introduction

Aims and ambitions

The growth of the cancer workforce is not keeping pace with the increasing demand for cancer services. The National Cancer Workforce plan (2017) and NHS England's People Plan (2020) both pledge to increase and transform the cancer workforce to support the delivery of 21st Century care. In order to achieve these ambitions and ensure Greater Manchester and East Cheshire (GMEC) has a sustainable supply of medical and non-medical cancer workforce to deliver safe and effective care for our cancer patients, a Cancer workforce strategy was developed.

Background and Context

The GMEC Cancer workforce steering group was established in February 2020 to oversee the development and implementation of a cancer workforce strategy. To inform the development of the strategy, the steering group built links with a number of specialty specific subgroups and supported the establishment of new groups were necessary (see diagram below).

The GMEC Cancer workforce strategy was developed in March 2021 and ratified by the GMEC Cancer Board in April 2021. To support implementation of the strategy, each subgroup was asked to provide a detailed plan related to the key strategic activities proposed in the strategy. This was collated into the following implementation plan, which outlines how the strategy will be achieved over the next 5 years.

The diagnostics workforce work across all specialties including cancer, and so the diagnostic elements in the GMEC Cancer workforce strategy will be superseded by diagnostic specific workforce strategies. A North West (NW) imaging workforce strategy has been developed and will be published in 2021, supported by a NW implementation plan. This will then be referenced in the cancer workforce implementation plan.

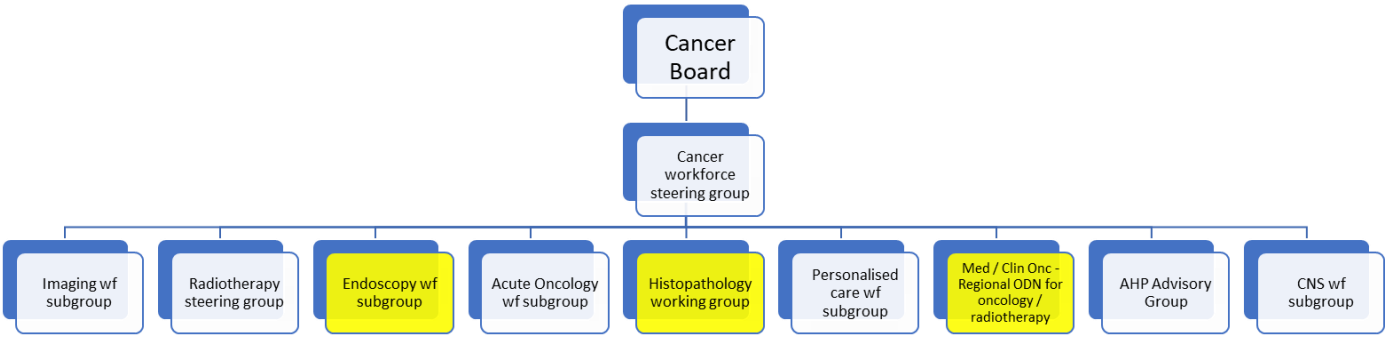
The establishment of a GM Imaging network is referenced in the GMEC Cancer Workforce strategy. This has been progressing well and so once fully established, the network will oversee implementation of the NW imaging strategy for GM. GM Cancer will continue to lead the imaging workforce review to inform future workforce models, and so plans related to this are included in the next section.

There has been system agreement on plans to establish a pathology network for GM and a Pathology Workforce Lead has been recruited. The Pathology Workforce Lead will oversee the development of a pathology workforce strategy and will lead a pathology workforce subgroup to support this. The Histopathology Workforce will be focused on initially, and so GM Cancer will maintain links with this subgroup and the pathology workforce strategy will be referenced in the GMEC cancer workforce strategy once developed.

There is currently no formalised endoscopy workforce subgroup and so activity referenced in the strategy has not been incorporated into the plan below. Endoscopy workforce workshops have taken place involving key stakeholders to inform plans, and so the overarching plan below will be updated in due course. GM Cancer will continue to lead the endoscopy workforce review to inform future workforce models, and so plans for this are included in the next section.

Implementation plan

The following plan will be implemented via the Cancer workforce steering group and subgroups.



Each subgroup referenced above will be accountable to the Cancer workforce steering group, which is accountable to the GMEC Cancer board. The Cancer workforce steering group is chaired by the Director of the Cancer Alliance.

The GMEC Cancer Workforce Steering Group will act as a space where key stakeholders from health and social care organisations across GM and EC come together to drive the delivery of workforce transformation programmes out of mutual gains and in pursuit of a common cause. It will also act as a forum for organisations to raise key workforce challenges impacting on cancer service delivery.

The Steering group will:

- oversee the development and implementation of a GMEC Cancer workforce plan
- ensure the cancer workforce plan supports delivery of phase 3 COVID recovery plans and the GM People Plan
- support the delivery of the ambitions set in the National Cancer Workforce plan, Long Term Plan (LTP), and NHS People Plan
- actively encourage system-wide workforce solutions
- actively manage and hold to account various subgroups to ensure the plan is delivered
- provide oversight of funding decisions for workforce transformation projects / international recruitment and workforce upskilling opportunities where resources are delegated to GM Cancer.

Imaging

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
Imaging workforce review	Libby Mills	Qualitative assessment of existing wf within a pilot site in GM to understand barriers & facilitators to overall service delivery	Nov 21	→					Qualitative workforce review with proposed future imaging workforce models
		Workshop to review new wf models with Diagnostic teams within the pilot site	Nov 21	→					
		Produce example options appraisal report explaining benefits of new wf models	Dec 21	→					
		Share report with all RSMs across GMEC	Jan 22	→					
		Conduct full workforce review across all trusts		→	→				
		System-wide workshop to ratify findings and review new wf models			→				

Endoscopy

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
Endoscopy workforce review	Libby Mills	Establish Links with Endoscopy CRG	Jul 21	→					Qualitative workforce review with proposed future endoscopy workforce models
		Workforce workshop to identify key areas of focus	Jul 21	→					
		Qualitative assessment of existing wf within a pilot site in GM to understand barriers and facilitators to overall service delivery	Nov 21	→					
		Workshop ideas for new wf models with endoscopy teams within pilot site	Dec 21	→					
		Produce example options appraisal report explaining benefits of new wf models	Jan 22	→					
		Share report with all endoscopy teams across GMEC	Feb 22	→					
		Conduct full workforce review across all trusts		→	→				
		System-wide workshop to ratify findings and review new wf models			→				

Increasing endoscopy training capacity via the NW endoscopy academy	Endoscopy Clinical Lead / CRG / Libby Mills	Coordinate GM training audit to identify training demand to feed into NW training audit	Sept 21	⇨					Training needs analysis
		Support development of a spoke site in GM to increase training capacity	Mar 22	⇨					Spoke site in GM established Increased training numbers
		Support the piloting of new roles in GM within endoscopy services			⇨				Increased capacity / skill mix within GM endoscopy teams

Therapeutic Radiographers

Key strategic activities	System Lead	Actions	Timeframes					Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
Role profile review through the radiotherapy pathway - including demographics, skills profiles, required infrastructure (education, service development, research development etc.)	National ODN Group in collaboration with professional bodies.	Contribute through the North West Radiotherapy ODN to the National role profile review		→	→	→	→		Output of role profile review paper
		Embed recommendations from the National role profile review to meet service need		→	→	→	→		Collaboration with the NW RT ODN Education Work stream to meet ODN Service Specification work programme
	Adrian Flynn	Establish workforce reporting data metrics and reporting dashboard		→	→	→			Production of measuring and reporting methodology
		Promote the use of Model Hospital and influence the development of its reporting structure		→	→	→			Production of measuring and reporting methodology

		Obtain consistency across the NW ODN, establishing a regional framework of the practice roles of site-specific and review radiotherapy practitioners, defining the terms enhanced, advanced and consultant							Production of measuring and reporting methodology
Develop non-registrant workforce to complement registrants	Adrian Flynn, John Archer	Promote and align with HEE AHP Support Worker Development Framework							Gap analysis against the HEE AHP Support Worker Development Framework
		Attract grants and bid monies to undertake specific projects, with a focus on healthcare support workers and aspirant radiographers (associate practitioner status support workers).							KPIS as defined by individual project bids
		Develop framework of opportunities to facilitate effective PDR conversation							
		Participate in the KickStarter programme	Dec 21						Recruitment of KickStarter staff

Explore cross functional working (therapeutic radiographers, nursing, clinical scientists, clinical technologists, engineering, clinical support workers). Think imaginatively about what professions can contribute to radiotherapy e.g. paramedic to provide acute oncology in department	Adrian Flynn, John Archer	Adopt a policy of offering roles to generic 'healthcare registered professionals' where specific professional registration is not a legal requirement. Investigate the opportunities for Physician Associate roles in radiotherapy. Ensuring that established ACP and PA roles are complimentary in radiotherapy inpatient and outpatient settings.						Diversity of professions contributing to the service
		Embed a process of challenging, and auditing decisions when creating new, and reviewing existing roles						Audit of meeting minutes and impact to strategic objective 1
Establish a leadership and coaching culture - Strategically deploy professional development funds (liberate the budget for use by those in the service as needed), apprenticeship levy and embed leadership at all levels (including pre-reg students) to change culture	Alison Sanneh	Engage with the annual Learning Needs Analysis programme						Amount of budget liberation and spend
		Promote the Christie Leadership Framework						Staff survey results
		Lobby for staff to access NHS Leadership Academy Offerings (including enhanced engagement in 360^{O} Facilitator, NHS Mentors, Clinical Supervisors, Coaching, Preceptorship and Action						Rate of staff accessing NHS Leadership Academy Offerings

		Learning Set Facilitators)							Number of staff accredited to conduct 360° feedback facilitation and coaching
Explore apprenticeships in radiotherapy, pre-registration and post-registration offerings. Embed apprenticeships to provide career development from pre-reg to post-doc	Alison Sanneh	Promote apprenticeships with the intention to secure additional funding to support the salary costs of radiography apprentices							Number of apprentices
Pilot the model of ACP in technical care in parallel with medical care – currently there are 6 ACP Apprentices following the 'technical model'	Alison Sanneh	Continue to engage with Health Education England to review the implementation of technical roles undertaking ACP and to support the development of Oncology ACP through shared experiences							
Support the College of Radiographers/Macmillian project reviewing student recruitment (RePair - Reducing Pre-registration Attrition and Improving Retention)	Alison Sanneh	Provide project input and support to the programme							None identified, national project
		Cross pollinate benefits from other projects to support the national output							
		Align with the NW RT ODN to sustain the outcomes							
		Contribute to widening access via a National Careers platform for Therapeutic Radiographer							

		Careers							
		Secure local career ambassadors in alignment with AHP ambassador opportunities							
Pilot the introduction of placements for pre-reg AHPs (starting with TR) utilising proton beam therapy service as part of the Clinical Placement Expansion Programmes (CPEP). GM is one of eight National CPEP projects.	Alison Sanneh	Completion of the CPEP Project	July 2021						As identified in the CPEP project bid and project plan
		Review and implement a sustainable clinical placement to enhance clinical training capacity for Therapeutic Radiographers							As identified by the CPEP final project report and options review

Medical and Clinical Oncology

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
Phase 1*									
Oncology workforce review looking at current workforce models across the different disease groups and across all sites to identify gaps	Yvonne Summers / Lip Wai Lee	Collate data from across all sites for all disease groups including numbers of ACPs and Prescribing Pharmacists (PPs), to include numbers, roles and responsibilities.	Dec 21	→					Workforce review and future workforce models options appraisal Gaps in service identified from analysis and business case developed. Reduced cancellation of clinics during leave.
		Support at risk services with NMP (pharmacist or ANP)			→				
		Review inpatient activity: - Evaluation of SpR changes in training i.e. Acute Oncology etc. - ward based consultant model at Withington.	Feb 22	→					
		Horizon scanning of treatment changes and new drugs to inform future volume of work / staffing requirements across disease sites.	Mar 22	→					

		Analyse data / gap analysis			→				
		Present internally and review options/action plan to address gaps/discrepancies over the coming years	Aug 22		→				
		All clinics to have non consultant staff who can assess patients and prescribe treatment. This will also enable all oncology clinics to continue when consultant is on leave					→	→	
Look at mechanisms for increasing numbers of Prescribing Pharmacists (Med Onc.) and ACPs (Med. & Clin. Onc.) and to make this consistent across sites / disease groups to build a consistent multi-professional Oncology workforce	Yvonne Summers/ Lip Wai Lee	Formulate an action plan for increasing the number of ACPs / PPs based on the horizon scanning and workforce review			→				Action plan in place to increase the Medical and Clinical Oncology workforce based on findings from phase 1 Identify number of NMP's and ANPs needed Training of additional staff
		Develop business cases for nurse/pharmacy led clinic as new therapy indications arise			→	→	→	→	

Explore the role of the Physician Associate in outpatient delivery of care.	Yvonne Summer / Lip Wai Lee	Review the PA role and opportunities to release current PAs from IP wards to trial role in the OP team							To be included in the action plan Pilot of the PA role in OP Increase in number of PAs working in Oncology in OP
		PA's to become part of lymphoma teams and begin OP training and service delivery							
		PA's to become part of major disease teams and begin OP training and service delivery							
		PA's to develop further with roles as sub investigator for research in selected disease areas							
		PA's to develop further with roles as sub investigator for research in all major disease areas							

**(implementation plan to be adapted once phase 1 has been complete)*

Acute Oncology

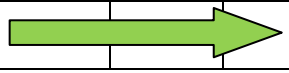
Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
Research and evaluate innovative ways to reduce the current workforce risks within AO - such as piloting the physician Associate role, ACPs, development plans for Band 4 Nursing Associate and above, apprenticeship, preceptorship schemes, AHP's and build in succession planning.	Louise Lawrence	Pilot role of PA at Tameside	Jun 21						Role sustained Increase in number of PAs working in AO across GM
		Evaluate the impact	Nov 21						
		Use the learning to develop a plan for increasing number of PAs in AO	Jan 22						
		Demonstrate consideration / evaluation for other roles such as NA, Apprenticeships, AHP's to supplement the AO workforce.	Jan 22						
Agree standardised and modular AO competency frameworks building on HEE CNS, UKONS & Macmillan existing work, and consideration of CPD provision	Louise Lawrence	Build framework from Network JD's	May 21						Published National Standardised AO Competency Framework Increased use of a standardised framework to inform job planning Collated positive feedback from teams.
		Take to National Standardisation Group representing 4 Nations	Jun 21						
		Pilot GM Cancer version within our own Network	Jul 21						
		Work with 4 Nations working group to use learning from GM pilots to aid National standardised tools	Sep 21						
		Adoption of 4 Nations - National passports & education developed through HEE.							

									Reduced variation in job roles and responsibilities.
Pilot the NHSE digital staff passport to enable cross boundary working relationships where appropriate	See employment models section								
Lead on an AO education package / workbook interlinking with educational academies and with National AO collaboration.	Louise Lawrence	Build from Network eLearning modules and in-house intelligence	Jan 21	→					Standardised education package agreed. Increased uptake across GM and roll out with other interdependencies Collated positive feedback from teams. Improved quality of care audited through AO specialist questionnaire. Reduced variation in access to training and education across AO teams.
		Validate modules	Jun 21	→					
		Take to National Standardisation Group representing 4 Nations	Jun 21	→	→				
		Pilot GM Cancer version within our own Network	Jul 21	→	→				
		Work with 4 Nations working group to understand; core, enhanced, advanced, expert levels and build of online resource.	Feb 22	→	→	→			
		Communicate and adopt National online versions.			→	→			

Clinical Nurse Specialists

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
Develop a NW CNS capability framework, funded by the National HEE Cancer and Diagnostics team. This will inform a national framework	Suzanne Lilley	Phase 1 – research	Aug 21	→					Baseline Workforce satisfaction questionnaire Focus groups to understand the impact Longer term measure of success - improved retention and a reduction in vacancy rates
		Collaborate with the Royal College of Nurses to define a National capability framework	Dec 21	→					
		Develop a digital framework			→				
GM and EC training / education framework	Suzanne Lilley	Work with national partners to support the delivery of the ACCEND National cancer career and education development programme. GM will lead the training and		→	→				National training and education programme for Cancer CNS Increased uptake

		education framework for CNS linked to CNS capability framework: Scope current training and education available for CNS Establish task and finish group to develop training programme framework Work with partners to define training and education framework							across GM Collated positive feedback from teams Improved quality of care audited through CNS questionnaire Reduced variation in access to training and education across GMEC Improved recruitment and retention
Raise the profile of the CNS role within the general nursing workforce	Lydia Briggs LCN T&G	Develop GM aspiring CNS training programme	Sept 21	⇨					Evaluation Summary Improved recruitment
		Pilot a 12 month programme utilising HEE monies with participating trusts across GM		⇨					
	CNS sub-group	Forge links with workforce leads to a) collate data around attrition and vacancy rates b) develop innovative	Mar 22	⇨					Greater understanding of the CNS role as measured through qualitative survey

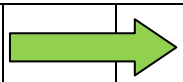
		approaches to recruitment - targeting newly qualified staff and nurses looking for pastures new							Reduced vacancy rates
Continue to build links with the wider GM nursing workstreams led by the Project Management Office (PMO) for Nursing, Midwifery and AHPs e.g. practice education development programmes to increase placement opportunities in cancer services, to help increase supply.	Suzanne Lilley	Scope what placements are currently being offered to student nurses in cancer services	Aug 21						Increased number of placements in cancer services in GM for student nurses Reduced vacancy rates.
		Develop a model to increase placement opportunities in cancer services	Oct 21						
		Pilot model							

Allied Health Professionals

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
To understand how AHPs are currently supporting people affected by cancer and to better utilise the generalist AHP workforce, GM is leading a NW survey. This will also help to identify any gaps in training / opportunities for upskilling and workforce development	SL/ZM / JD	Launch NW survey to understand baseline position	Jan 21	⇨					NW Survey report
		Analyse results	April 21	⇨					
		Present recommendations to key stakeholders to secure funding for an L&D programme.	July 21	⇨					
A NW training programme to address the gaps identified in the survey, to upskill generalist AHPs, improve confidence in a priority area, and provide opportunities for continued development of specialist knowledge and skills for AHPs working in cancer pathways	SL/JD/ZM	Develop HEE proposal to secure funding for short term project management to achieve this strategic activity*	Oct 21	⇨					Established AHP cancer training and education framework
	SL/VD	Establish task and finish group and other stakeholder engagement required for this activity	Q3 21/22	⇨					
		Review existing training programmes and identify gaps	Q4 21/22	⇨					

		Work with key stakeholders to develop training programmes to address gaps identified for generalist AHPs, based on the Macmillan AHP competencies		→					
		Investigate opportunities within the GM Cancer Academy project and other NW educational projects to include AHP suitable upskilling/CPD L&D opportunities e.g. ACCEND		→					Linked to individual project outputs
		Work with key stakeholders to promote and encourage uptake for both Specialist and Generalist AHPs to undertake training as defined by their competencies			→				Increased uptake of cancer-related training Evaluate impact of the training on practice
GM will look at mechanisms to improve whole population access to specialist oncology AHPs.	AHP Advisory Board (AAB) Chair	AHP Advisory Board to review existing documentation on 'good' AHP workforce requirements for individual tumour pathways and make amendments/updates as required.	Q3 to Q4 21/22	→					Refreshed documentation stipulating 'good' AHP workforce requirements for tumour-specific pathways.

	Paula Breeze /Victoria Dickens	Share tumour specific documentation with the individual pathway boards (PWB) for their review. Ascertain whether these are fit for purpose or whether there are any gaps identified by MDT members within the PWBs							
		Link with AHP Advisory board, GM AHP networks and PWB members to ensure AHP champions are present within each PWB. Leadership training and peer support to be offered via the GM AHP faculty to ensure PWB AHP representatives feel confident and competent to contribute as required .within PWB meetings							AHP 'champion' representative present among each GM Cancer PWB membership, with necessary skills and confidence to contribute effectively
	Chair/Victoria Dickens/ Paula	Liaison with ICS to influence AHP representation in wider ICS strategic commissioning discussions and relevant board meetings							Strong AHP representation (including with a cancer focus) in newly formed ICS organisation structures.

	Breeze + other Chief AHPs Chair/GM Ca Workforce Lead AHP rep people board/ Chief AHPs	Review access to specialist AHPs, if whole population access is not achieved: a) Explore funding opportunities for further roles to be created b) Investigate ability to restructure access to specialist AHP provision e.g. via digital staff passport c) Challenge established referral processes which prevent AHPs referring to other AHPs for specialist cancer service provision.							Evaluate whether whole population access to specialist cancer AHP provision has been achieved, using refreshed pathway documentation for benchmarking
	AHP Faculty/ AAB Chair/GM Ca Workfor	Develop a mentorship model involving specialist cancer AHPs 'GM AHP Cancer Champions' to support generalist AHPs to deliver 'specialist' input, with the advice, guidance, upskilling and supervision they need to do this confidently and competently.							Improved confidence in generalist AHPs with supporting cancer patients

	ce Lead								
Securing future workforce supply e.g. via the apprenticeship route	AAB Chair/ /Paula Breeze / Suzanne Lilley (AHP Faculty) / AHP Council	Use established links with GM AHP faculty to: a) identify opportunities to increase AHPs working in cancer e.g. support worker / apprenticeship workstreams b) Review cancer component of apprenticeships for 'generalist' support workers c) Explore opportunities for AHP cancer-specific apprenticeships e.g. therapy assistants. d) influence academic institutions within GM to include cancer specialist topics within							Improved cancer knowledge, skills and behaviours in generalist AHPs Increased supply into specialist roles

		pre-reg courses.							
		Review existing placement opportunities Develop placement model for pre-reg AHPs in cancer services							Increased number of placements in cancer-specific settings or in generalist setting with cancer theme.
		Revisit rotation post opportunities across organisations to give newly qualified AHPs the opportunity to work in specialist cancer services – potential use of the digital staff passport							Increased number of AHP rotation arrangements incorporating cancer-specialist posts.
Link in with the GM AHP workstreams led by the Project Management Office (PMO) for Nursing, Midwifery and AHPs.	AAB Chair /Paula Breeze / Suzanne Lilley	Establish formal links with GM AHP work streams including appropriate membership of relevant GM wide groups	Dec 21						Cancer AHP representative attending GM AHP Council.
Support the sustained delivery of Prehab4Cancer across GM: **a) Support the training/upskilling and CPD of existing (& future) Prehab4Cancer GM Active staff**	P4C B7/Zoe Merchant /NB/KO	Maintain links with GM Active via the GM Cancer Prehab4Cancer programme steering group. Input into the GM Active academy	Ongoing						AHP presence in Prehab4Cancer and recovery programme service

b) **Identify specialist healthcare professionals who would be required to deliver Prehab4Cancer for wider groups of patients with increased specialist needs**		Request training and upskilling from GM Active staff TO GM Specialist AHPs	Ongoing						development, training provision, research and delivery.
		Use membership of national work streams to continue to influence discussions around prehab/rehab workforce. Implement agreed guidance, applying for further funding opportunities where they become available	Ongoing						GM AHP representation in national prehab/rehab work streams including Q community.

**plans may need to be reviewed if no funding secured*

Cancer Support Workers

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
GM will collaborate with other NW and national cancer alliances to develop a Training and Education Framework, funded by HEE in line with the National People Plan.	GM Cancer wf and education team	Recruit Project manager	June 21	→					Project manager in post
		Scope national training and education developed / in development		→	→				Directory of all national training and education
		Develop standardised training and education framework			→	→			Standardised Training and education framework Feedback from CSW in GM Training programme adopted by all trusts in GM for newly recruited CSW

		Pilot new roles based on gaps identified and pilot new training programme			→				Recruitment to new roles. Feedback from recruits and clinicians/patient experience
Continue to promote the Cancer Care Coordinator role	GM Cancer wf and education team	Webinar during GM Cancer virtual cancer week	May 21	→					Attendance Session feedback
		Share evaluation of the CCC transformation project with all relevant networks	Aug 21	→					Feedback from stakeholders Project roles sustained Increased numbers of CCCs across GM
Establish GM wide Cancer support worker network to quality assure practice and provide seamless personalised care for cancer patients	GM Cancer wf and education team	Conduct a mapping exercise to identify current cancer support worker roles across GM	Jan 21	→					Established CCC community of practice Systems in place to measure delivery of personalised care and measure quality Standardised practice across GM.
		Produce a gap analysis based on mapping data to understand the current provision of personalised care by trust and tumour site	Mar 21	→					
		Establish Cancer Support Worker Champions within each trust		→	→				
		Develop community of practice to share best practice and standardise practice							

Pilot cancer support worker roles in Primary Care to support seamless personalised care for cancer patients.	See Primary care section below

Physician Associates

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
GM Cancer will work with the GM Physician Associate steering group to develop a strategy to support the increase in number of Physician Associates working in cancer services in GM	Jess Docksey	Work with HEE to re-establish a GM Physician Associate Steering Group and develop a GM strategy for PAs	Oct 2021	→					Key stakeholder at the steering group GM PA strategy in place
		Work collaboratively with the HEE PA Ambassador for cancer (once recruited) to conduct a scoping exercise of: - number of PAs working in cancer service in GM - interest from Cancer Pathway Boards in piloting the PA role - which trusts would be interested in hosting the placement of PAs	Dec 2021	→					Delivery of full scoping exercise

		Work with motivated trusts and pathways to develop a 2 year plan for PA placements using a 4 monthly rotational model to provide opportunity for education and advancing clinical practice for PAs. Link in with HEIs.	Mar 2022	→					2 year plans in place with input from trust service managers and GM pathway board members
		Evaluate the impact of placements on increasing number of PAs in cancer services			→				Number of PAs working in cancer services compared to baseline
		Develop a business case template for trusts			→				Collaborative development of business case template
Building on the success of the Physician Associate Preceptorship in Cancer Services pilot, the cancer academy will develop a competency framework and training programme for PAs and other generalist roles moving into specialty areas.	Susan Todd	Pilot a competency framework for PAs working in urology	Jun 2021	→					
		Expand the above into a multiprofessional competency framework for the non-medical workforce		→	→				
Raise the profile of the PA role and where they fit within a multi-professional cancer team.	Jess Docksey	Evaluate the Urology Physician Associate Preceptorship	Aug 2021	→					Evaluation produced and approved by steering group Roles sustained
		Share with trusts across GM to showcase success/lessons learned and raise the profile of the role within cancer services	Sept 2021	→					Increased interest in piloting the role in other pathways – mapping across GM

		Deliver webinar as part of GM Cancer virtual cancer week	May 2021						Webinar attendance Webinar feedback
		Deliver webinar as part of the GM Workforce Summit	May 2021						Webinar attendance Webinar feedback

ACPs

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
To address gaps in the Consultant workforce, GM Cancer will support providers to increase the number of ACPs working in cancer services	GM Cancer wf and education team	Scoping exercise to Identify no. of ACPs supporting cancer pathways	Oct 21	→					Increased number of ACPs working in cancer services in GM
		Develop case studies to show impact of this role on service delivery / alleviating pressures on the consultant workforce	Nov 21	→					
		Share with pathway boards	Nov 21	→					
		Identify pathways / trusts interested in piloting the role	Nov 21	→					
		Develop a business case template for interested trusts	Dec 21	→					
		Support them with the application for HEE funding	Feb 22	→					
As part of the cancer academy, we will increase the number of ACPs working in urology and identify any training gaps	GM Cancer wf and education team	Develop a business case template for interested trusts	Dec 21	→					Increased no. of ACPs working in urology cancer services
		Work with trusts / individuals to prepare application for HEE funding	Feb 22	→					
		Evaluate impact of the role on service delivery			→	→			

Through the cancer academy, GM Cancer will work with Higher Education Institutions to influence the cancer content of generic ACP programmes to increase interest in working in cancer as a specialty.	Susan Todd	Identify current ACP programmes with an interest in cancer							Increased cancer content in GM ACP programmes
		Support development of content / bolt on modules were required							

Volunteers

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
Pilot the role of the cancer volunteer in GM **The learning from this will be shared with other trusts to help achieve the vision of increasing the number of cancer volunteers across GM and EC. The cancer volunteer role will be clearly defined to support people affected by cancer and as part of a 'grow your own' workforce model to create a sustainable talent pipeline into the cancer workforce.**	GM Cancer wf and education team	WWL model ready to pilot	April 21	⇨					Increased number of cancer volunteers across GM Standardised roles Standardised training Increased retention
		Evaluate impact and share findings	Mar 22	⇨					
		Recruit project support officer	Sept. 21	⇨					
		Scoping exercise - number of cancer volunteers working across trusts - how are volunteers currently being utilised to support cancer services across GM - recruitment processes and training available	Dec 21	⇨					
		Work with trusts to develop different models for utilising volunteers	Jan 22	⇨					
		Standardise role descriptions, training and education where necessary	Feb 22	⇨					

Cross Cutting Activities

Education – Cancer academy

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
Pilot the Cancer academy model in urology with a view to rolling this out to other pathways to adapt and adopt	Susan Todd	Develop a cancer academy website	Oct 21	→					Clearly defined Cancer academy model Adoption of the model by at least one other cancer pathway Standardised training and education framework for
		in-depth scoping (including training needs analysis) of the current urology non-medical clinical workforce across the care settings to inform the model & training/education required	Oct 21	→					
		Produce educational offerings for common areas of clinical practice	Mar 22	→					

		Develop multi-professional capability/career frameworks for professional groups	June 22						the non-medical clinical workforce
		Pilot a skills lab (virtual/F2F) to support skilling and upskilling the urology workforce	June 22						Multiprofessional competency framework Improved retention Reduced unwarranted variation in practice.
		Develop a cancer academy model that can be adopted/adapted for other cancer pathways/specialities	June 22						
		Project evaluation	June 22						
		Rollout model for other pathways							

Apprenticeships

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
To explore alternative routes into the cancer workforce and increase supply, GM Cancer will work with key stakeholders to increase the uptake of relevant apprenticeship courses e.g. ACP apprenticeships, Healthcare Science, Nursing Associates etc.	Cancer Workforce and Education Team	Link in with relevant GM workstreams supporting the uptake of apprenticeships e.g. GM PMO for nursing, midwifery and AHPs; HEE ACP programme;		→					Increased uptake of apprenticeships
		Support coordination of HEE funding for Assistant practitioners in radiography	Dec 21	→					Increased uptake of AP apprenticeships across GMEC

Psychological training and education for the cancer workforce

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
Coordinate HEE funding to support CNS to be upskilled in advanced communications and providing psychological level 2 support for cancer patients	Suzanne Lilley	Work with Lead cancer nurses to coordinate funding across GM trusts	Dec 21	→					Increased workforce satisfaction / improved practice – measured through qualitative survey
Develop a GM Cancer training strategy to support ongoing delivery of Level 1 and 2 psychological skills training to the cancer workforce	Sinead Collins	Establish a task and finish group	Sept 21	→					Psychology training and education strategy for the cancer workforce
		Scoping of 'offers' for CNS supporting other long term conditions	Dec 21	→					
		Develop a training and education strategy		→	→				

		Explore sustainable funding solutions							
Pilot MECC for cancer	Sinead Collins	Establish task and finish group to review / develop MECC for cancer content	Nov 21						MECC for cancer training programme for all non-clinical staff Improved patient experience Improved levels of staff confidence / communication
		Work with LCNs to agree trusts to pilot new training programme	Dec 21						
		Pilot programme	Mar 22						
		Evaluate impact							
		Recommendations for wider rollout across GM							

Workforce race equality

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
Link in with The Greater Manchester Health and Social Care Partnership (ICS) Workforce Race Equality work streams	Jess Docksey	Explore GM wide mechanisms for capturing workforce race equality data for the cancer workforce	Dec 21	→					Improved data collection
		Establish workforce race equality subgroup and develop an action plan	Oct 21	→					
		Source representatives of the cancer workforce to pilot the '*Race Equality Change Agents Programme'* (RECAP) led by the GM ICS	Mar 22	→					Change project to improve workforce race equality within pilot sites
		Evaluate the impact of the RECAP programme on creating change within the cancer workforce			→				Evaluation report Increased equality within the cancer

		Link in with other GM initiatives to improve Workforce Race Equality e.g. AHP Faculty							workforce

Improving employment model

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
Pilot implementation of the NHSE / I Digital Staff Passport to encourage movement of the cancer workforce.	Jess Docksey	Identify cancer services interested in piloting the passport	May 21	⇨					Acute Oncology identified for pilot pathway
		Conduct a 6 week initial survey open to all Acute Oncology nurses across GM to provide current position from the AO nursing workforce with feedback regarding benefits and concerns relating to passport	Aug 21	⇨					Complete survey results to inform project model
		Trusts to undergo the registration process for formal passport sign up and completion of DPIA	Aug 21	⇨					All trusts registered to use the passport
		Development of a resource pack to detail passport benefits, registration process, communications resources	Sept 21	⇨					Identified trusts / AO teams to take part in the pilot
		Develop model for using passport based on service need	Sept 21	⇨					

		Development of engagement and governance plan	Sept 21	→					
		Identification of staff for movement across the system including: - Nurses - AHPs/Cancer Support Workers - Pharmacy - Trainee ACPs/Doctors	Oct 21	→					Individual clinicians identified for movement
		Support identified staff through training and verification process for formal use of the passport	Nov 21	→					All identified staff undergone necessary training and verification process
		Pilot the passport		→	→				Number of staff registered and verified Volume of movement around the system
		Evaluate pilot success through number of trusts and individuals signed up, volume of movement, case studies throughout pilot, end of project survey			→				An evaluation demonstrating impact and an improving employment model proof of concept.

Primary care

Key strategic activities	System Lead	Actions	Timeframes						Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
The Cancer Academy will support healthcare professionals working in primary care settings with their training and education needs relating to specific cancer pathways – this will initially be piloted in urology	Susan Todd	Scoping exercise to understand training needs of the primary care wf relating to urological / cancer care	Nov 21	→					Comprehensive training package to support the non-medical clinical workforce in primary care to deliver urological care to patients / better support patients affected by urological cancers
		Link in with gateway C to develop education offerings for the primary care workforce based on the gaps identified during the scoping exercise		→	→				
Explore opportunities for collaboration to pilot new roles in PCNs such as cancer care coordinators / CNS boundary spanning roles to ensure	Suzanne Lilley	Engage key partners to explore opportunities for collaboration	July 21	→					Secured funding to pilot new link roles across primary and

provision of seamless personalised care to cancer patients.		Develop proposal to secure funding for piloting new roles to bridge links between primary and secondary care	Oct 21						secondary care

Community services

Key strategic activities	System Lead	Actions	Timeframes					Measure of success (KPI)
			Target date	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	
The Cancer Academy will support training and education needs of healthcare professionals working in the community / community services to enhance skills, knowledge and confidence to provide care to people affected by cancer. This will also enhance the opportunities for early identification, referral and diagnosis of cancer.	Susan Todd	Scoping exercise to understand training needs of healthcare professionals working in the community / community services providing urological / cancer care	Sept 21	→					Comprehensive training package to support the non-medical clinical workforce working in community settings to deliver urological care to patients / better support patients affected by urological cancers
		Develop education offerings for relevant professionals groups		→	→				
Training and education for community based AHPs	Suzanne Lilley	NW AHP cancer training and education programme will serve community AHPs *(see AHP implementation plan for further detail)*							

Risks and mitigating actions

There are a number of potential risks to delivering the Cancer workforce strategy in GMEC, which are outlined below. All risks will be further reviewed, prioritised and managed via the Cancer Workforce Steering Group.

	Strategic Risks & Implications	Mitigation actions
1	The workforce strategy will require significant financial investment not all of which has been accounted for in locality & GM plans. Insufficient funding could limit the scale and pace of implementation plans.	The GMEC Cancer Workforce Steering Group will work with local providers, regional and national bodies including the GM Integrated Care System, HEE, NHS England / Improvement, Macmillan and CRUK to explore funding opportunities for workforce initiatives in order to maximise its impact for the benefit of all GM organisations.
2	Locality and GM plans may not yet reflect the scale of investment required to deliver sustainable improvements in the cancer workforce	The GM Cancer Workforce team will work with local providers to encourage alignment between the system and local cancer workforce strategies to drive forward implementation / provide greater visibility on the need for investments into cancer workforce initiatives in localities.
3	Current cancer performance / competing operational challenges across the Health & Social Care system could distract from the transformation priorities and not encourage a more long term view of cancer workforce needs	The Cancer workforce steering group will pro-actively engage with all key GM forums to ensure the long term ambitions and needs of the GMEC cancer workforce remain firmly on the agenda and momentum is maintained at all times

Virtual Cancer Week May 2021

User Involvement

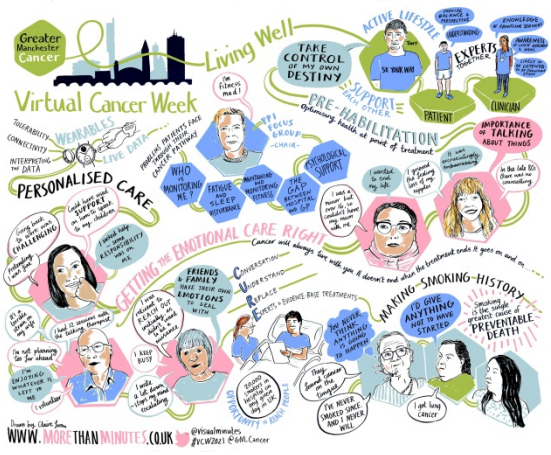
An overview of User Involvement in Greater Manchester Cancer's Virtual Cancer Week 2021

22 Service Users registered with the Greater Manchester Cancer User Involvement Programme were involved with the planning and delivery of Virtual Cancer Week. Using co-production methodology, Service Users were involved in planning, making short films, panel discussions and a User Involvement Session.

Planning Virtual Cancer Week

Patrick was involved in the planning of Virtual Cancer week with The Christie School of Oncology Team as well as taking part in panel discussions on "How to get emotional Care right" & "User Involvement Session"

Day 1 – Living Well



Session	What	Who
Welcome	Film – Prehab & 5KYW	Tony
How to get Emotional Care Right	Panel Film	Patrick Caitlin
Digital Approaches to Self-Managed care	Panel	Steve

Welcome Session

Tony sits on the Prehab for Cancer Steering Group, amongst other things. Tony opens the day with a frank description of his cancer diagnosis and treatment and why it is so important to be healthy, what difference fitness has made to him and his involvement with 5KYW and Prehab.

"How to get Emotional Care Right"

Caitlin is a member of the Young Voices Network, the small community equivalent for Teenage & Young Adult Pathway Board. Caitlin's film was a very honest portrayal of the psychological effects of a cancer diagnosis and treatment on a young person. She discusses the psychological support she reached out for and the difficulties of dealing with early menopause as a teenager.

Digital Approaches to Self-Managed Care Panel Session

Steve is a member of the EMBRaCE project Steering Group amongst other things. Steve talked about the work he is doing to look at digital solutions to self-managed care and how a diverse group of service users are involved so that they can understand whether the technology will be acceptable to different groups in our communities.

Day 2 – Early Diagnosis

Session	What	Who
Welcome	Film – Early Diagnosis of Lung Cancer	Karen
The Best Timed Prostate Pathway Project	Panel – Chair	Mike

Welcome Session

Karen is a member of the Lung Small Community. Karen is very keen to convey the message about the importance of early diagnosis, and an appeal to people to come forward if they have a cough that lasts more than a few weeks, particularly during Covid.

The Best Timed Prostate Pathway Project Session

Panel Discussion

Mike sits on the Programme Assurance Group, UI Steering Group and Prostate Small Community amongst other things. He is also Vice-Chair with NHS PPV. Mike discusses on the panel his work on the Best Timed Prostate Pathway and how fragmented the pathway was at the beginning. He also talks about the role of the Pathway Navigator and how influential this role has been to improving the experience and shortening the pathway for patients.

Day 3 – Covid Recovery

Session	What	Who
Welcome	Film – diagnosis through Covid	Charmain
Welcome	Film – Cancer Treatment through Covid	Ilva
Prehab Cancer & Recovery Programme	Panel	Tony

Welcome

Charmain is a member of the Breast Small Community amongst other things. She opens Day 3 by talking about the fear of going into hospital for diagnosis during the first wave of Covid and how important it was to get over that fear to get the treatment she needed.

Ilva is a member of the Breast Small Community. She opens the day by talking about looking forward to starting her life again after chemotherapy and surgery, which took place during the first lockdown. She discusses the devastation she felt when she heard that her family, who live in Germany, could not visit to support her as their boarders closed. The experience of that isolation make Ilva reassess what she wanted from life and influenced her move back to her home country of Germany to be close to her family.

Prehab for Cancer

Tony sits on the Prehab for Cancer Steering Group, amongst other things. A Panel Session was chaired by Tony as a member of the Prehab Steering Group where they discuss the changes that needed to be made to the programme due to Covid and the lack of face to face exercise sessions. We also heard from a patient who undertook the prehab programme.

Day 4 – International

Session	What	Who
Advances in Palliative Care Services	Panel	Nic
Cancer related Fatigue & Fatigue Management	Film	Tom

Advances in Palliative Care Services

Nic is a Service User Representative on the Lung Pathway Board amongst other things. Nick took part in this panel as part of the work he did with the Palliative 7 Day Care project. Nick speaks about the difference it would have made to him as a carer for his wife to have the availability to speak to someone when needed about palliative and end of life care and decisions.

Cancer Related Fatigue & Fatigue Management

Tom is a Service User Representative on the Haematology Pathway Board. Tom has a particular interest in how cancer diagnosis and treatment can affect young people. He describes the effects of fatigue resulting from treatment on his life and the measures that he took with his family and healthcare professionals to manage this. Tom says “it’s ok to change plans if you don’t feel up to it”

Day 5 – Engaging Communities

Session	What	Who
Engaging Communities	Film	Nabila
Screening Update, how can we improve	Panel	Nabila
What is User Involvement?	Panel	Sally, Patrick, Annie, Sinead Collins, Jane Cronin
What is User Involvement?	Films	Nadine Jo Sally & Julie

Welcome

Nabila is a Service User Representative on Cancer Board and a member of the Breast Small Community, amongst other things. She talks about understanding the needs of local populations to enable health equalities to be delivered. It's important to engage with local communities so they understand what cancer services are available and equally important to listen to those communities about the experiences they have had.

Nabila was also a member of the panel session on Screening Update, how can we improve, bringing her experience both as a service user and through her work life in cancer screening to the conversation.

Panel Session

"What does User Involvement actually mean? What's it all about and what difference can it make to cancer services?"

A Working Group was set up involving 6 service users who co-produced the User Involvement Panel Discussion together with Jane Cronin & Sinead Collins. It was important to focus the session on encouraging people who are newly diagnosed to come forward, particularly from seldom heard from groups and to make user involvement more accessible by "myth busting" some of the terminology involved.

Nadine is a member of the Breast Small Community amongst other things. She says "If there are aspects of your care where you felt things could be improved, then user involvement is a fantastic way to influence professionals and to work with clinicians and people in cancer services"

Annie is a member of the Breast Small Community, amongst other things. Annie took part in the User Involvement session Panel. She talks about what co-production means to her "it's an equal partnership between the people who work in the NHS to improve cancer care and the patients and families"

Sally & Julie are both Service User Representatives on the Lung Pathway Board. They spoke about the importance of their work on Treatment Summaries in making them relevant to patients with the correct information and written in a language that is understandable to patients and families.

Sally has been involved in many different ways as a service user representative including the redesign of the breast cancer pathway. Sally took part in the User Involvement session Panel. She says "We are there to be the critical friend. We are there to say what hasn't worked and how can we make that better, we are not there to complain"

Patrick talks about the variety of user involvement he has been involved with. Patrick took part in the User Involvement Session Panel. He says "I've found a confidence in speaking publicly as a result of my user involvement"

Jo is a service user representative on the Breast Pathway Board, a member of the User Involvement Steering Group, a member of the Breast Small Community, amongst other things. She made a short film about the work she has done in developing an infographic to alert patients and GP's to the signs and symptoms of secondary breast cancer. This infographic has now been incorporated into GM Cancer Stratified Breast Cancer Treatment Summary and adopted by NHS England amongst others. The infographic was accepted as a poster at Virtual Cancer Week and Association of Breast Surgery Conference 2021.

A HUGE THANK YOU to all of the service users who gave their time and experience to help make Virtual Cancer week a success.

Jane Cronin
User Involvement Manager | Greater Manchester **Cancer**

07500 577751 | gmcancer.org.uk | @GM_Cancer

My pronouns are: She/her/hers

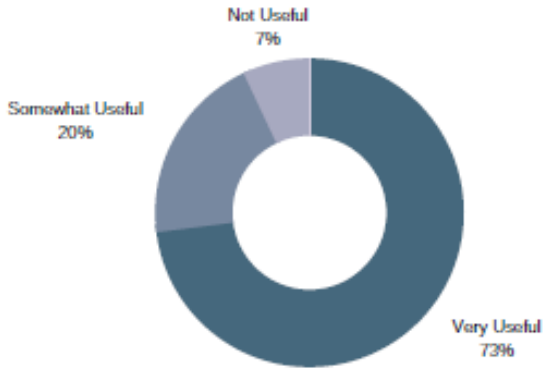
What is User Involvement?

75
TOTAL WATCHES

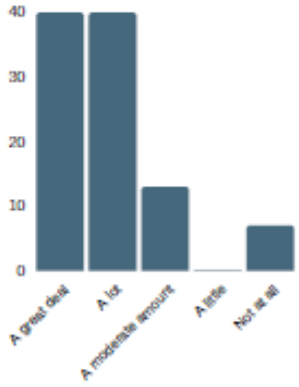
48
LIVE

27
ON-DEMAND

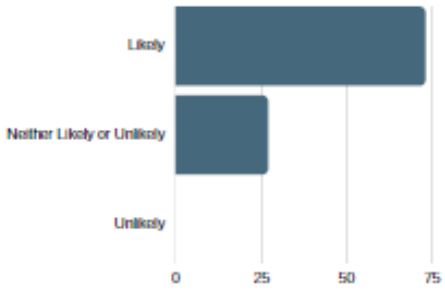
How useful was the session in updating your knowledge?



Did the session challenge your thinking?



Will you change your practice as a result of this session?



Would you recommend this session?

Additional Comments:

- Fantastic session - thank you & well done to Jo for all she does in promoting the infographic & for the campaigning she does for access to drugs & trials.
- Very insightful session, thank you
- Fabulous presentation, I didn't realise how involved the user groups are, well done everyone
- Should be compulsory viewing for all primary and sec care workers
- Very insightful. Patient/Service user involvement is so important on so many levels. Thank you to everyone involved for sharing their stories Are there any early diagnosis, screening programme or primary care groups that have service user involvement? claire.rimmer3@nhs.net