Greater Manchester Cancer Board Agenda

Meeting time and date: Monday 25th July 2022, 3pm-5pm.
Venue: MS Team Virtual Meeting
Chair: Dave Shackley, Co Chair: Anita Rolfe.

#	Item		To	Lead	Time
1	Welcome and apologies Minutes from the previous meeting, 23rd May Action log and matters arising.	Verbal Paper 1, Pg.1 Paper 1 Pg. 12	- Approve Update	Dave Shackley Anita Rolfe	10’
2	Overview of the GM Health System	Verbal	Update	Dave Shackley	20’
3	Cancer Alliance & ICB Update	Paper 2, Pg. 13	Discussion	Claire O’Rourke Roger Spencer	30’
4	Model of Care for Lung	Paper 3, Pg. 33	Update	Matthew Evison Alison Jones	20’
5	Cancer Recovery & Performance Key Risks & Operational Improvement	Presentation (Separate Attachment) Paper 4, Pg. 56	Update	Lisa Galligan Dawson	20’
6	Papers for Information: GM Cancer Pathway Board Work Programmes update Q1 22.23	Paper (Separate Attachment)	Update	Susan Todd	-
	GM Cancer Annual Report	Paper 5, Pg. 73	Approve	Anna Perkins	-
	GM Cancer Conference & Awards	Paper 6, Pg. 105	Update	Anna Perkins	-
7	AOB	Verbal	Discuss	All	20’

The next meeting is scheduled Monday 3rd October 2022, 3pm-5pm at The Life Centre 235 Washway Rd, Sale M33 4BP

Greater Manchester Cancer Board
Minutes and Actions

Meeting time and date: Monday 25th July, 15:00pm-17:00pm
Venue: Virtually, via MS Teams

Members present			
Name	**Role**	**Organisation/ Representation**	**Attendance 2022/2023**
Anita Rolfe (AR)	GM Cancer Board Co-Chair	Stockport CCG	2/5
Dave Shackley (DS)	Director & Clinical Lead	GM Cancer	2/5
Claire O'Rourke (COR)	Managing Director	GM Cancer	2/5
Sarah Taylor (ST)	GP/ Primary Care Lead	GM Cancer	2/5
Lisa Galligan-Dawson (LGD)	Performance Director	GM Cancer	2/5
Suzanne Lilley (SL)	Cancer Workforce Lead	GM Cancer	2/5
Alison Jones (AJ)	Director of Cancer Commissioning & Early Diagnosis	GM Cancer / GM Joint Commissioning Team	2/5
Anna Perkins (AP)	Communications and Engagement Lead	GM Cancer	1/5
Rhidian Bramley (RB)	Diagnostics Project Clinical Lead	GM Cancer	2/5
Nabila Farooq (NF)	User Involvement Rep PaBC	GM Cancer	2/5
Leah Robins (LR)	Rep for GM Chief Operating Officers	Northern Care Alliance Group	1/5
Sarah Price (SP)	Chief Officer	GM Health & Social Care Partnership	1/5

In attendance		
Name	**Role**	**Organisation/Representation**
Beth Sharratt (BS)	Project Manager (Health and Social Care VCSE Engagement)	GMCVO
Caroline Davidson (CD)	Director of Strategy	Manchester Foundation NHS Trust
David Wright (DW)	TYA Lead Nurse & Clinical Lead for TYA	Manchester Foundation NHS Trust
Jemma Woodward (GWo)	Deputy Lead Cancer Nurse	Manchester University Foundation Trust
Janet Castogiovanni (JC)	Director of Performance	GM Health & Social Care Partnership
Jonny Hirst (J.Hirst)	Answer Cancer Programme Manager	Answer Cancer
Lisa Spencer (LS)	Associate Director of Strategy	Northern Care Alliance NHS Group
Matthew Evison (ME)	Lunch Clinical Pathway Lead	Manchester University Foundation Trust
Professor Robert Bristow MD PhD (pRB)	Director	Manchester Cancer Research Centre
Richard Booton (RBo)	Clinical Director, Directorate of Lung Cancer & Thoracic Surgery	Manchester University Foundation Trust
Roger Prudham (RP)	Consultant Gastroenterologist / Lead Cancer Clinician	Northern Care Alliance NHS Group
Sadhbh Oliver (SO)	Senior Team Administrator	GM Cancer
Teresa Karran (TK)	Regional NHS Relationship Manager	CRUK
Tom Thornber (TT)	Director of Strategy	The Christie NHS Foundation Trust
Victoria Dickens (VD)	Director of AHPs	Northern Care Alliance NHS Group

Zoe Merchant	Programme Manager – Lung Health Check Programme	Manchester Foundation NHS Trust
GM Cancer Team Members	Alexandra Riley	GM Cancer
	Alison Foxley	GM Cancer
	Becky Cook	GM Cancer
	Jane Cronin	GM Cancer
	Jaqie Lavelle	GM Cancer
	Jess Docksey	GM Cancer
	Joseph Henshaw	GM Cancer
	Lauren Kelly	GM Cancer
	Louise Lawrence	GM Cancer
	Louise Retout	GM Cancer
	Paul Keeling	GM Cancer
	Philip Graham	GM Cancer
	Sarah Lyons	GM Cancer
	Sue Sykes	GM Cancer
	Stella Ruddick	GM Cancer
	Tara Schaaffe	GM Cancer

Apologies			
Name	**Role**	**Organisation**	**Attendance 2022/23**
Roger Spencer (RS)	Co-Chair / Chief Executive	The Christie Foundation NHS Trust	1/5
Alison Armstrong (AA)	Associate Director	GM Cancer	1/5

Cathy Heaven (CMH)	Programme Director of Cancer Education	The Christie NHS Foundation Trust	1/5
Rob Bellingham (RobB)	Managing Director	GM Joint Commissioning Team	1/5
Professor Janelle Yorke (JY)	Executive Chief Nurse & Director of Quality	The Christie NHS Foundation Trust	1/5
Susan Todd (ST)	Programme Director for Transformation	GM Cancer	1/5

1. Welcome and Apologies, Minutes of the last meeting & Action log and matters arising	
Discussion summary	DS gave welcomes and introductions and listed apologies for the meeting. The minutes from the March board were ratified and all open actions were reviewed. SO to update the action log accordingly.
Actions and responsibility	No action required.

2. Overview of the GM Health System	
Discussion summary	DS provided several updates relating to areas in the GM Health System. • David Thompson was successfully recruited to the role of Clinical Lead for Research. • DS noted that there had been limited updates surrounding the 10-year plan / war on cancer plan. However, publications were expected around September. If published in time the paper would be brought to the October board and an update provided. • It was recognised that the Integrated Care System went live on the 1st July. • The Targeted Lung Health Check programme had been agreed in principle to be rolled out further in due course, via a PCN based, rather than locality-based, approach. STa highlighted that the national screening committee was also considering if it could possibly become a part of the formal national screening programme. NF noted that there had been positive feedback from the user representatives in relation to model of care for lung and TLHC programme. AP provided an update about how the User Involvement review was progressing, noting that it was in its final stage which consisted of 10-minute online survey. Stakeholders who are engaged in the UI programme, as well as user representatives, were encouraged to complete the survey. Please find the link to

	the survey as follows: https://survey.euro.confirmit.com/wix/3/p148844003053.aspx?Sample=1 COR highlighted that the GM system was in a state of heightened escalation due to the increase in staff absences following the most recent wave of covid. Feedback was provided from recent meetings including GM Gold Command. It was recognised that the emergency department and NWAS were facing pressure and suffering significant delays. 20% of patients in hospital were suffering with covid, hospital capacity sat at 96-98% in GM and no reason to reside figures sat at over a thousand. COR assured the board that members of the alliance were in regular attendance of Community Co-ordination Cell, Gold Command and PFB, and were championing what was going on from a cancer service perspective in GM services. It was recognised that whilst there had been growth in the cancer backlog since March, innovation work was still a continued focus of the alliance.
Actions and responsibility	No action required.

3. GM Cancer & ICB Update	
Discussion summary	The paper from the national cancer team, detailing the role of the cancer alliance in the new ICB, was shared with the board membership ahead of the meeting. Please see the paper 'Improving cancer outcomes: guidance on how ICBs and Cancer Alliances will work together' for full details. COR noted the various elements of work that the alliance would lead on going forward in the ICB. With recognition that the alliance would have primary role in supporting system delivery of cancer improvement metrics and innovation, sharing best practice across the system, and supporting the system in achieving the aims outlined in the long-term plan and planning guidance. Emphasis was placed on the role that GM would continue to play in carrying out existing innovation and taking forward new clinical innovation. It was recognised that the board would inform the system of where GM was from a cancer perspective, and how GM is performing against the planning guidance/ 10 year plan. 3 Key areas were highlighted by TT in relation to the transition to the ICB.

	1. Connections had been put into place in the system and work was being undertaken to mitigate any challenges that could arise from transitioning to the ICB. Such as alliance ICB workshops. 2. Performance and the move to system oversight performance. 3. Strategic planning and looking into the delegation of specialist commissioning/ specialist services to ICB level that were currently the responsibility of NHSE. With the intention to delegate from April next year. LS noted that many specialised services ran across multiple ICSs, with GM being a large importer of specialist service patients. AJ assured that a close working relationship would continue with the GM CCGs, with physical discussions planned with the CCG around how the new system will work. TT highlighted that the system would move from a cost-based model to a patient allocation model which would allow funding to flow with patients across regional borders. DS queried if the Cancer Board would be the new recommendation body who approves items which different groups need to be involved in. DS also highlighted that work could not be looked at from an isolationist GM perspective, and work needed to be linked in with the national and regional teams who could provide specific help and guidance.
Actions and responsibility	No action required.

4. Model of Care for Lung	
Discussion summary	ME presented on the Model of Care for Lung. This document had been produced by the GM Cancer Lung Pathway Board and commissioners in GM. It aimed to provide a clinical consensus from across the region around what the optimal care for symptomatic lung patients should be. Covering a variety of aspects relating to care. Please see the 'Model of care for lung' paper included in the board papers for specific details. It was recognised that the paper supports the earlier diagnosis agenda and the standardization of care to reduce inequalities. Enabling GM to look at unwarranted variation across the system. As well as providing a useful framework for services and hospitals to work against. <u>Work in relation to the Model of Care for Lung.</u>

	Individual areas of care had been asked to provide the small lung improvement group with a gap analysis to see where they were against what the model of care strives to achieve. Results from which would provide an opportunity to see what the barriers are to achieving this. It was expected that results from the analysis would likely be ready to circulate in 3 months' time. <u>Reception of Paper</u> There was praise from the board over the papers inclusion of a GM strategic overview and key strategic ambitions that sit across the system. It was recognised that the paper provided an example of pathway led work, which TT noted was a prime example of how work in the GM system should continue to be formed moving forward in the new ICS. It was recognised that this paper had been signed off by the Directors of Commissioning and PFB, who provided their support and endorsement to deliver in the ways described in the paper. There was discussion around how this paper could be made to reach front line services rather than being a paper that required leadership to filter information down into the system. STa noted that Primary Care would be in a good position to circulate wider messages relating to the Model of Care. AR highlighted that there were multiple avenues that enable information to enter the system. Such as GM System Quality groups and Locality Quality groups, which every locality were required to have. RB also suggested that information could be cascaded in training that was already set up with frontline staff, such as a workshop being held for lead radiologists.
Actions and responsibility	▪ SO to add to the 'Model of Care for Lung' to a future board agenda to enable membership to see the changes that have occurred as a result of its publication. ▪ Model of Care for Lung presentation to be listed at the next GM Quality group.

4. Cancer Recovery & Performance Key Risks & Operational Improvement	
Discussion summary	The 'Cancer Operational Performance & Recovery' paper was shared in advance of the meeting for membership to review. The paper detailed the work being undertaken in localities at a system level, and provided a comprehensive overview of where GM were as a system in relation to cancer, GM trajectories, and the delivery requirements for the year. Please see the paper for further detail.

	LGD noted that there was a new responsibility, following the shift to the ICB, for the alliance to support operational delivery and recovery. Which needed to be done through a pathway approach and working with partner organisations. <u>Key areas performance.</u> Please see the performance presentation slides for specific data figures. - It was recognised that referral rates remained elevated however work was being undertaken to try and ensure the correct referrals were entering the system. i.e. Dermatascope training and FIT testing. - It was recognised that GM had an increasing PTL. - GM Cancer Waiting Time (CWT) performance had been affected by the NCA IT challenges which prohibited reporting. This in turn meant that accurate CWT figures for GM would not be visible until 6 months' time. - There continued to be variation in the treatment for patients across the system based on locality. - Whilst planning trajectories appeared to be achieved, LGD highlighted that there were several incomplete records which would likely change GM's performance status once complete. <u>Key actions and Updates</u> - It was recognised that the Complex One Stop Lung clinic went live in June 2022. ME reported how the clinic was progressing, noting the success so far and reduction in the time taken for a decision to treat. - Work was being implemented around demand management and the appropriateness of referrals entering the system. - LGD noted that there had been an additional focus on cancer improvement in GM Gold, PFB, COOs and EMDs with extra steps of escalation being taken around performance trajectories. - A GM Cancer recovery panel had been set up and would be hosting monthly pathway specific meetings to look at the recovery of pathway performance. <u>Questions</u> STa noted that they felt to improve the quality of referrals, there needed to be better communication between primary and secondary care. STa asked if the board would support making communication regarding referrals between primary and secondary care a priority across all the trusts in GM. TT queried how the current challenges in system would be managed as GM went into its winter months. LGD noted that winter was being brought forward by GM Gold, and a GM cancer improvement week. LGD also felt that the system needed to improve its surgery recovery numbers, as six-week surgical treatment averages sat at around 250 per week when an average of 310 needed to be achieved per

	week to create improvement. It was also felt that targeted work needed to continue such as single queue that would drive performance improvement.
Actions and responsibility	SO to add a 'Complex One Stop Lung Clinic' update to October Board agenda.

6. Papers for Information: GM Cancer Pathway Board Work Programmes update Q1 22.23 GM Cancer Annual Report GM Cancer Conference & Awards	
Discussion summary	The GM Cancer 2 year annual report was approved by the board. AP provided details around the GM Cancer conference and the awards evening that was being created in conjunction with the conference. It was noted that the event would be hybrid and the themes of the conference would be equality, innovation, and collaboration. It was asked that members of the board let colleagues in the system know about the awards and ask all who would be interested to contribute.
Actions and responsibility	No action required.

10. AOB	
Discussion summary	It was noted that the next meeting would be held as a face to face event, with recognition that the structure of the agenda would be altered with a focus on prevention, operational performance and personalised care & treatment.
Actions and responsibility	No action required.

The next meeting is scheduled Monday 3rd October 2022, 3pm-5pm at The Life Centre 235 Washway Rd, Sale M33 4BP.

Action Log

Prepared for the 3rd October GM Cancer Board

Log No.	AGREED ON	ACTION	STATUS
25.21	March 2022	DS to share summary paper that was sent to PFB alongside other documentation relating to the Ten-Year Plan with members of the board.	**Update.** Awaiting reviewed copy back from the national team. To be circulated once released and circulated with the national published 10-year 'war on cancer' plan expected July 2022 (July or September board) Update 25.07.22 – No update yet provided from the national team. It was assured that once confirmed the plan will be circulated and updated at the nearest board.
30.21	March 2022	SO to circulate the GM Cancer Draft Annual Report alongside the minutes from the March Board minutes.	**Closed 25.07.22 –** Report circulated and approved by the board membership.
02.22	July 2022	Model of Care for Lung presentation to be listed at the next GM Quality group.	
03.22	July 2022	SO to add a 'Complex One Stop Lung Clinic' update to October Board agenda.	

Classification: Official

Publication approval reference: PAR1474

Improving cancer outcomes: guidance on how ICBs and Cancer Alliances will work together

Version 1, 30 May 2022

Contents

1. Purpose of this document

1.1. This guidance sets out a national framework within which Cancer Alliances will work together with Integrated Care Boards (ICBs) when they are legally and operationally established on 1st July 2022.

1.2. Building on previous guidance that outlined the role of Cancer Alliances (see pull out box), this document is designed to support local discussions between Cancer Alliances and ICBs as they set out their roles and responsibilities from July 2022.

ICS guidance and Cancer Alliances

The *ICS Design Framework* states that Cancer Alliances will continue to:

> ***"use their expertise to lead whole-system planning and delivery of cancer care on behalf of their constituent ICSs, as well as providing clinical leadership and advice on commissioning."***

Working together at scale: guidance on provider collaboratives sets out further detail on how Cancer Alliances will work with provider collaboratives:

> ***"Provider collaboratives […] will work with Cancer Alliances. Cancer Alliances will continue to lead whole-system planning and delivery of cancer care on behalf of their constituent ICSs, as well as providing clinical leadership and advice on commissioning."***

ICS implementation guidance on effective clinical and care professional leadership states that:

> ***"ICSs should […] build on the expertise of existing clinical and care professional networks; for example, Cancer Alliances and networks covering areas like cardiac, renal and respiratory care. This is not to replace existing networks; it is about aligning them within the ICS."***

2. About Cancer Alliances

2.1. Cancer Alliances are unique. As the primary vehicle for delivery of the NHS Long Term Plan ambitions for cancer and improvements in cancer performance, they bring together partners across complex cancer pathways to deliver the best care and outcomes for patients. They have also been central to the success in maintaining cancer services during the pandemic.

2.2. Cancer Alliances were established in 2016, following the recommendations of the Independent Cancer Taskforce.[1] The Taskforce recognised the need for capacity and leadership for delivering improvements to cancer services, much of which had been lost following an overhaul of the former cancer networks in 2013.

Cancer Alliance responsibilities

2.3. Cancer Alliances are currently responsible for leading the planning and delivery of cancer services and for leading work across their constituent ICS(s) to:

- **diagnose cancer earlier and improve survival,** through the delivery of Long Term Plan projects like Targeted Lung Health Checks and Faster Diagnosis Pathways, and through reducing treatment variation;
- **improve patient experience and quality of life,** supporting providers to implement new follow-up pathways for personalised care;
- **reduce health inequalities in cancer services,** using latest data and working with partners to identify solutions; and
- **speed up cancer pathways,** reducing waiting times and improving operational performance.

2.4. There are 21 Cancer Alliances and their geographical boundaries reflect cancer patient flows, which often span more than one ICS. This means that around half of Cancer Alliances map to more than one ICS. In other parts of the country, particularly where there are larger ICSs, the Cancer Alliance covers just one ICS (see mapping at Annex A).

[1] *Achieving World-Class Cancer Outcomes. A Strategy for England 2015-2020.* Available here.

2.5. Alliances bring together partners at neighbourhood, place and system level, working together through the Cancer Alliance board to lead whole-system planning and delivery of cancer care and its improvement across their footprint. This approach benefits patients by ensuring that all the partners who contribute to the delivery of complex cancer pathways work effectively together.

2.6. Alliances also provide funding and capacity to secure cancer transformation, creating the evidence base to enable systems to adopt new approaches, and provide clinical leadership to cancer services and those working with them.

3. About ICBs

3.1. ICBs will bring partner organisations together in a new collaborative way with common purpose. They will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place.

3.2. ICBs will be responsible for refreshing annually their five year plan that sets out how they will meet the health and healthcare needs of their population (all ages) within their area (which should reflect national and local priorities). ICBs will also be responsible for allocating resources to deliver the plan across the ICS, as well as establishing joint working arrangements with partners.

4. The relationship between Cancer Alliances and ICBs

4.1. Cancer Alliances already lead the planning and delivery of cancer services and their improvement across their local systems. It makes sense for ICBs, when legally and operationally established, to look to the Cancer Alliances to continue to undertake these roles on their behalf from July 2022, because:

- Alliances have the clinical expertise, knowledge of innovation and best practice in cancer care, and understand the local operational landscape for cancer;

- they have funding and a dedicated staff team already delivering improvements in cancer services; and,

- this will ensure continuity in delivering the NHS's Long Term Plan priorities.

4.2. For Cancer Alliances, acting with the full authority of their ICBs will reinforce their leadership role for cancer services within their local systems.

5. Cancer Alliance roles

5.1. Cancer Alliances bring together partners from across their area (including representatives from place and system level and from provider collaboratives) to undertake, as a minimum, four main roles on behalf of their ICB(s):

- **Planning** – Alliances will contribute to ICB plans by leading the development and delivery of their cancer element – strategic plans for cancer covering both the delivery of the LTP ambitions for cancer and activities to support the delivery of cancer services in line with waiting times standards and national standards for specialised cancer services. The plan developed by the Alliance will be the integrated, system-level plan for cancer for its constituent ICB (or ICBs where an Alliance maps to more than one ICS).

- **Whole-system and whole-pathway delivery** – Alliances will work with provider collaboratives and other system partners to support the effective delivery of cancer pathways, including the operational standards for cancer, and embed best practice for cancer care. They will also work across the whole pathway, providing the link to partners including: prevention, screening and public health services; primary care; diagnostic networks; Operational Delivery Networks (eg. for

radiotherapy); Community Diagnostic Centres; and, end of life care providers. Alliances will also ensure alignment with wider system plans, for example on workforce, health inequalities, digital and research and innovation.

- **Clinical leadership** – Cancer Alliances will facilitate clinical expert groups for cancer to provide clinical leadership for the local system and to inform strategic and operational decisions related to transformation and improvement projects across the ICB(s).

- **Strategic commissioning** – as part of their planning role, Cancer Alliances will advise their ICB(s) on the commissioning of routine and specialised cancer services, including associated diagnostic services, to ensure that there is sufficient capacity to meet the needs of people with cancer or suspected cancer.

5.2. ICBs may also wish to ask Cancer Alliances to take on additional roles, based on local circumstances, and should lead local discussions with their Cancer Alliance to agree this where appropriate.

6. What this means in practice for Cancer Alliances and ICBs

Planning

6.1. The ICS Design Framework states that Cancer Alliances will continue to use their expertise to lead whole-system planning and delivery of cancer care on behalf of their constituent ICSs.

6.2. While ICBs will retain responsibility and ownership of the ICB five year plan, they are expected to ask Cancer Alliances to develop the cancer elements of this plan, including as part of the annual refresh of the plan.

6.3. Cancer Alliances are well placed to bring together stakeholders to ensure co-ordination and consistency so there is an integrated plan between multiple partners. The plan will include local priorities, which reflect local

circumstances and opportunities, as well as the ICB contribution to the delivery of the NHS's national cancer priorities, including implementation of national programmes like the Targeted Lung Health Checks programme (as set out in the Long Term Plan and annual planning guidance).

6.4. To avoid duplication, the expectation is that the plan developed by the Alliance will be the integrated, system-level plan for cancer for its constituent ICB(s). Where an Alliance covers more than one ICB, it is expected that the Alliance plan will form the cancer element of the five-year plans (and their annual refresh) for each of its constituent ICBs. The integrated plan will cover actions at both an ICS level and at a supra-ICS level, and will set a framework for any local activities at a place or neighbourhood level.

6.5. Each ICB will be responsible for approving and signing off the cancer elements of its own five year plan, and so the Alliance will need to satisfy each ICB that the plan meets the health needs of its population.

6.6. Cancer Alliances will also have a line of accountability to the Regional Director and National Cancer Director (see 7.11 below) for the Service Development Funding provided to them, and will need to demonstrate how their plan will contribute to the delivery of national cancer priorities. The Alliance plan will form the basis of its funding agreement signed by the Chair of the Cancer Alliance (on behalf of the Cancer Alliance Board, which includes ICB representative(s)), Regional Director and the National Cancer Director. Again, to avoid duplication, it is expected that the same integrated, system-level plan will normally be used for this purpose.

Case study: Planning and delivering transformational change across two systems in West London

RM Partners (West London Cancer Alliance) spans North West and South West London ICSs. The Alliance has a long history of collaboration with both systems, working with partners to improve the health and wellbeing of their population and reduce health inequalities.

One example is the delivery of non-site specific diagnostic pathways across both systems. There is currently 100% population coverage across both ICSs, with the pathways being delivered by services across 10 sites by seven Trusts.

Successful delivery has been enabled by an Alliance-wide clinical pathway group, spanning both ICSs, which brings together clinical representation from each of the live and proposed sites, develops protocols for key common presentations, and holds quarterly clinical 'retrospective MDTs' to share learning.

In addition, the Alliance's governance – in particular, the RM Partners Cancer Alliance Board which brings together senior representatives from all partner organisations – has ensured joint accountability and delivery of the shared plan and transformation programmes for cancer.

Over the coming years, the Alliance will have a greater emphasis on working with local communities through place-based partnerships to improve early diagnosis and support people with cancer, build on the strong track record of provider collaboration in cancer which was so evident in the success of the collective response – led by the Alliance – to COVID-19, and continue to convene and provide clinical leadership and expertise for cancer across both ICSs.

Whole-system and whole-pathway delivery

6.7. Cancer Alliances already work with many local stakeholders, such as public health, primary care, screening providers, diagnostic networks and specialised commissioning teams, to lead a whole-system approach to pathway and performance improvement and to the delivery of LTP priorities. The real benefit of Alliances comes from their ability to bring together partners from across the whole pathway to deliver more joined-up and streamlined pathways for patients. This role has proved particularly effective during the pandemic, with Cancer Alliances in many areas leading system-wide approaches to ensure the continuity of cancer services.

6.8. Under future ICB arrangements, there is a particular opportunity for Alliances in working with provider collaboratives, which many Alliances are already doing. As set out in *Working together at scale: guidance on provider collaboratives*, Cancer Alliances will enable provider collaboratives to deliver

on their cancer objectives through delivering an integrated plan for cancer across systems.

6.9. In practice this means that provider collaboratives can look to Cancer Alliances to lead a data-driven approach to improvement in cancer performance and outcomes across the system as a whole, and to establish mechanisms to ensure effective joint working between trusts and other partners within the local system. Cancer Alliances receive Service Development Funding to support the planning and delivery of system objectives, including improvements against the cancer operational standards and faster diagnosis, through extending the coverage of non-specific symptom pathways and ensuring that cancer referrals meet timed pathway milestones.

Case study: Whole system working across Greater Manchester

The Greater Manchester (GM) Cancer Alliance has developed a model for cancer pathway design and delivery, bringing together the 10 localities of GM. The Cancer Alliance provides a single planning and coordinating function for cancer services across the ICS. The Alliance take a matrix approach to link each of the locality provider and commissioner groups into system-wide planning for cancer, involving representatives from all trusts, CCGs and PCNs and including operational and clinical leaders.

The Cancer Alliance ensures effective, whole-system delivery through their single, shared planning and delivery 'entity' operating at a GM system level. This takes a clinical pathway approach to planning from prevention through to personalised follow-up care. Joined up working with other stakeholders, including the voluntary sector and patients, is also a vital part of achieving these objectives.

By bringing together partners across their system, Greater Manchester Cancer Alliance are able to deliver cancer transformation, for example through establishing a GM-wide data system and using this to inform conversations about capacity and demand across the whole system. This enabled key step changes in the recovery of cancer services, including seeing a reduction in 104 day waiters from March 2020 of 1300 to 319 in October 2021. This was despite significant system-wide pressures, including from COVID-19.

Clinical leadership

6.10. Cancer Alliances will continue to convene clinical expert groups for cancer and provide clinical leadership for cancer for their local systems, to help inform the planning, commissioning, and delivery of cancer services at local and system levels. As the ICS implementation guidance on effective clinical and care professional leadership makes clear, it makes sense for ICSs to draw on these existing structures where they require clinical input and leadership for cancer.

6.11. Cancer Alliances have established tumour-site specific clinical groups that cover the whole pathway to provide clinical advice, input and leadership for specific transformation and improvement projects. These clinical groups also have an important role to play in:

- reducing any unwarranted variation in access to, experience of and outcomes from treatment across their local system;
- overseeing action to implement the recommendations of clinical audits, GIRFT reports and other improvement support initiatives; and,
- ensuring the rapid uptake of new technology and approaches across the local system.

Case study: Providing clinical expertise to transform cancer services in Kent and Medway

In July 2018, just 49 per cent of patients with suspected prostate cancer in Kent and Medway received first treatment from urology services within the 62-day period. In response to this, Kent and Medway Cancer Alliance's (KMCA) Urology Tumour Site Specific Group (TSSG) undertook a system-wide review of the prostate pathway. The review highlighted the different processes for diagnosing prostate cancer across the hospitals and helped to identify key changes that would not only have a big impact but be sustainable long-term.

Changes implemented as a result of the review included fully implementing the timed prostate cancer diagnostic pathway; procuring new equipment to reduce patient travel time; and, putting in place guidance that urology triage should be both nurse and consultant led, meaning patients could have their tests soon.

A year on from the review, in July 2019, 87.6 per cent of patients with an urgent referral for suspected prostate cancer received first treatment from their urology service within 62 days. This improvement has been maintained despite the challenges of the pandemic, with KMCA sustaining a high level of performance on the urological cancer pathway throughout.

6.12. Cancer Alliances will also nominate clinical leads to contribute to the development of national and regional commissioning policy and other relevant policy/guidance.

Strategic commissioning

6.13. Cancer Alliances will continue to have a central role in advising on the commissioning of all cancer services (including specialised services), in particular through provision of clinical leadership and advice. ICBs or groups of ICBs with responsibility for cancer commissioning should look to their Cancer Alliance to provide advice on clinical and system priorities to inform commissioning decisions.

6.14. In addition, individual Cancer Alliances may, depending on local circumstances, play a more direct role in commissioning and contracting arrangements, such as taking on additional responsibility in relation to cancer commissioning.

Case study: Commissioning in Kent and Medway

In Kent and Medway, the cancer commissioners report directly to the Cancer Alliance Programme Director. These commissioners are currently employed by the CCG but, through these reporting arrangements, are effectively embedded into the Cancer Alliance structure. The Kent & Medway Cancer Alliance (KMCA) is coterminous with one ICS and one CCG which supports this arrangement.

The commissioners' remit is to commission services which will support delivery of the cancer plan, which has been developed by KMCA on behalf of its ICS. This brings commissioning expertise directly into the Alliance and ensures that the ICS, CCG and Cancer Alliance are working together effectively to integrate cancer services transformation into the commissioning cycle. Having the commissioners

integrated within the Alliance allows this process to start sooner, which will benefit patients as new services and pathways can be rolled out quickly.

There are also four planned care commissioners across Kent and Medway, who meet monthly with the cancer commissioners. These links between the cancer commissioning team and planned care colleagues at system and Integrated Care Partnership (ICP) level ensure impact and wider system issues are factored in, so that any implications for the whole cancer pathway are identified and issues are mitigated.

The rollout of FIT testing across Kent and Medway has demonstrated the benefits of this way of working. FIT was quickly introduced as a triage tool for suspected colorectal cancer in secondary care at the start of the pandemic, and it is now being rolled out across Kent and Medway to support initiation of a high-risk pathway in primary care. Because the cancer commissioners sit within the Cancer Alliance, the Alliance can influence and enable these commissioning decisions so that the process to initiate and sign off the pathway is more streamlined than it would have been previously.

The Cancer Alliance and Kent and Medway ICS intend to continue to work in this way once the ICB is established in July 2022.

7. Governance, decision-making, funding and accountability

Governance

7.1. Every Cancer Alliance will continue to have a board which brings together senior representatives from its constituent organisations, with representatives covering the whole patient pathway. The board members should be able to make decisions on behalf of their organisations and be able to contribute actively to leading delivery of the Cancer Alliance plan.

7.2. A Cancer Alliance board will be chaired by a senior leader from one of the Alliance's constituent organisations, often a Trust or ICB Chief Executive.

The board will usually include senior clinical and managerial representatives from the following:

- ICB(s);
- local commissioners;
- specialised commissioning;
- NHS England and NHS Improvement regions;
- GPs and Primary Care Networks;
- NHS Trusts and provider collaboratives;
- Integrated Care Partnership(s);
- local authorities;
- patient/lay representative; and,
- community and voluntary sector health organisations.

7.3. Some members will be able to fulfil more than one of the above roles. There remains a clear expectation that Alliances will have in place a robust mechanism for engaging systematically with wider stakeholders, including patients, the public and patient organisations.

Case study: Involving people affected by Cancer in West Yorkshire and Harrogate

An award-winning patient panel is helping to ensure that the voices of people affected by cancer are influencing and shaping the work of the West Yorkshire and Harrogate Cancer Alliance.

Comprising more than 40 members – primarily patients and carers – the panel is hosted by Healthwatch Wakefield, with Alliance funding. Healthwatch employs a panel co-ordinator to support those already involved and to recruit new members from across the whole of the region. The focus has been to secure membership from all local areas; with experience of a range of different tumour groups and pathways, and from a diverse range of communities and backgrounds. Priority will be given to extending this recruitment drive in 2022.

The patient panel has continued its work during the pandemic, shifting from face-to-face to online engagement, and members have received support and skills development to continue their work.

The Alliance delivers the cancer priority programme of the West Yorkshire Health and Care Partnership (Integrated Care System). The engagement and delivery model for the panel is shared as good practice across the ICS, and has already been used to inform the development of the Planned Care citizens' panel. This has facilitated joint working on common issues, such as the development of rapid diagnostic services and community diagnostic centres.

There is also a shared objective across the panel and the Alliance Cancer SMART cancer champions programme to reduce unacceptable variation in cancer screening uptake and raise awareness of signs and symptoms to promote early diagnosis.

By working with people and communities using a co-production approach, the Alliance is able to reach communities and networks that the NHS would struggle to reach alone.

Decision-making

7.4. To facilitate the Cancer Alliance role in leading whole-system planning and delivery of cancer care, it is important that there is a clearly defined relationship between the Cancer Alliance and ICB.

7.5. It would be for ICBs and CAs to agree who from the ICB should sit on the Cancer Alliance board – the nominated individual will have delegated responsibility to make decisions on behalf of the ICB (in accordance with the ICB Scheme of Reservation and Delegation). Where an Alliance maps to more than one ICS, each of the relevant ICBs should nominate a member to sit on the Alliance board.

7.6. In addition, to ensure that decisions made by the Cancer Alliance board are effectively feeding into those of the ICB, ICBs may wish to consider the following options:

- A member of the Cancer Alliance board could sit on a committee of the ICB to be involved in wider decision making and share input on behalf of the Cancer Alliance.
- Inviting the CA Chair to join the board of the ICB, which will be a decision of the chair of the ICB. All members of the board of the ICB must be set

out in the ICB's constitution approved by NHS England and NHS Improvement.

7.7. Governance and decision-making arrangements may change over time to reflect local circumstances.

Funding

7.8. The *ICS Design Framework* confirms that Service Development Funding for cancer will continue to be provided to Cancer Alliances to enable them to continue to deliver their existing roles on behalf of their constituent ICB(s). Service Development Funding through to 2023/24 was confirmed in the LTP Implementation Framework. This funding is intended to support the delivery of Alliances' core activities to drive operational improvement for cancer and to fund the local implementation of national LTP commitments for cancer.

7.9. National funding is provided to Cancer Alliances to give them the certainty to plan, employ staff and to ensure continuity of delivery of LTP programmes like Targeted Lung Health Checks. This national funding will be the minimum funding that Alliances receive, and ICBs will be able to supplement this through their devolved funding.

Accountability

7.10. NHS England and NHS Improvement will continue to have ultimate oversight over performance and delivery, however this will be discharged in future in partnership with systems. The ICB will be formally accountable for the effective delivery of cancer services for their local population.

7.11. Cancer Alliances will be accountable to:

- their ICB(s) for the effective delivery of the roles set out at 5.1 above. This will principally be measured through the effective delivery of the outputs and outcomes set out in the Cancer Alliance plan; and,
- the National Cancer Director and their Regional Director for the effective use of the Service Development Funding made available to Alliances and for the delivery of their contribution to national priorities reflected in the Cancer Alliance plan.

7.12. Each Cancer Alliance will provide a quarterly report on progress to its ICB(s) and to NHS England and NHS Improvement through its Regional Director.

7.13. The ICB and Cancer Alliance may also wish to agree additional local accountability mechanisms, particularly where the ICB has made available additional funding to the Alliance.

Annex A – Cancer Alliance/ICS mapping (correct at date of publication)

Region	Cancer Alliance	ICS
North West	Cheshire and Merseyside	Cheshire and Merseyside Health and Care Partnership
	Greater Manchester	Greater Manchester Health and Social Care Partnership
	Lancashire and South Cumbria	Healthier Lancashire and South Cumbria
North East and Yorkshire	Humber and North Yorkshire	Humber and North Yorkshire Health and Care Partnership
	Northern	North East and North Cumbria ICS
	South Yorkshire and Bassetlaw	South Yorkshire and Bassetlaw ICS
	West Yorkshire and Harrogate	West Yorkshire and Harrogate Health and Care Partnership
Midlands	East Midlands	Leicester, Leicestershire and Rutland ICS
		Joined up Care Derbyshire
		Nottingham and Nottinghamshire ICS
		Lincolnshire ICS
		Northamptonshire ICS
	West Midlands	Staffordshire and Stoke on Trent ICS
		Coventry and Warwickshire ICS
		Shropshire and Telford and Wrekin ICS
		The Black Country and West Birmingham ICS
		Birmingham and Solihull ICS
		Herefordshire and Worcestershire ICS
East of England	East of England – North	Cambridgeshire and Peterborough ICS
		Suffolk and North East Essex ICS
		Norfolk and Waveney Health and Care Partnership
	East of England - South	Hertfordshire and West Essex ICS
		Mid and South Essex ICS
		Bedfordshire, Luton and Milton Keynes ICS
London	North Central London	North London Partners in Health and Care
	North East London	North East London Health and Care Partnership
	South East London	Our Healthier South East London

	West London	North West London Health and Care Partnership
		South West London Health and Care Partnership
South East	Kent and Medway	Kent and Medway ICS
	Surrey and Sussex	Sussex Health and Care Partnership
		Surrey Heartlands Health and Care Partnership
		Frimley Health and Care ICS
	Thames Valley	Buckinghamshire, Oxfordshire and Berkshire West ICS
	Wessex	Hampshire and the Isle of Wight ICS
		Dorset ICS (*part of South West region)*
South West	SWAG	Gloucestershire ICS
		Somerset ICS
		Bristol, North Somerset and South Gloucestershire ICS
		Bath and North East Somerset, Swindon and Wiltshire ICS
	Peninsula	Devon ICS
		Cornwall and Isles of Scilly Health and Care Partnership

For further information, please contact england.cancerpolicy@nhs.net

Title of paper:	**Lung Cancer Model of Care**
Purpose of the paper:	To update the GM Cancer Board on the progress with the GM Lung Model of Care – development and implementation
Summary outline of main points / highlights / issues	Lung cancer is the most common cause of cancer death in men and women accounting for more deaths than breast and bowel cancer combined. The crude incidence rate in England in 2017 was 86.9 per 100,000 population in males and 67.0 per 100,000 population in females. There were 38,888 newly diagnosed cases of lung cancer in England in 2017, 18,568 in males and 20,320 in females. The GM Lung Pathway Board have developed and endorsed a Model of Care for Lung Cancer and propose this as a whole GM approach. The model sets out quality standards and describes the expectation for lung cancer service delivery that will improve outcomes for all patients with suspected and diagnosed lung cancer. There is evidence of inequality across GM with regard to access to specialist diagnostics, patient optimisation and treatment. Agreeing a model of care that will apply to all lung cancer service providers will allow the GM health system to work collaboratively to ensure equal access to all patients. This model builds on the best time pathway principles and the GM optimal lung cancer pathway, which will help support meeting Cancer Waiting Times standards and targets GM Provider Federation Board and CCG Directors of Commissioning have approved this document and support the Alliance working with Provider organisations on its implementation, allowing local teams to identify and address variation in services and the level of care delivered. The Cancer Alliance Pathway Board will therefore now commence work with colleagues in GM Provider organisations to undertake a review and gap analysis against this model of care and develop delivery / implementation plans to address and reduce variation.

Consulted	GM Lung Pathway Board GM Clinical Commissioning Groups – Directors of Finance, Directors of Commissioning, Cancer Commissioning Managers Provider Federation Board
Recommendations	Cancer Board are asked to note and support the way forward with the implementation of the GM Model of Care
Authors of paper and contact details	**Name:** Dr Matt Evison, Pathway Board Clinical Lead / Consultant Chest Physician, MFT **Name:** Dr Seamus Grundy, Consultant Respiratory Physician, Northern Care Alliance NHS FT **Name:** Alison Jones **Title:** Director of Commissioning – Cancer Services (Interim) **Email:** alison.jones8@nhs.net

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

GM Joint Commissioning Team
GM Cancer Alliance

Model of Care for Lung Cancer in Greater Manchester

Document Control	v2.0 April 2022
Service	Lung Cancer
Commissioner Lead	GM Integrated Care System / GMHSCP
Nominated Providers	Manchester University NHS Foundation Trust Northern Care Alliance NHS Foundation Trust Royal Bolton NHS Foundation Trust Wrightington Wigan & Leigh NHS Foundation Trust Tameside & Glossop Integrated Care Foundation Trust Stockport NHS Foundation Trust
Period	April 2022 – March 2024
Date of Review	April 2023
Authors	Seamus Grundy, Chair GM Lung Diagnostic Sub-group Matt Evison, Lead Clinician for Lung Cancer, GM Alison Jones, Director of Commissioning for Cancer Services, GM Coral Higgins, Macmillan Cancer Commissioning for Manchester
Consultation	GM Cancer Lung Pathway Board GM Cancer Board

1. Population Needs

National context

Lung cancer is the most common cause of cancer death in men and women accounting for more deaths than breast and bowel cancer combined. The crude incidence rate in England in 2017 was 86.9 per 100,000 population in males and 67.0 per 100,000 population in females. There were 38,888 newly diagnosed cases of lung cancer in England in 2017, 18,568 in males and 20,320 in females.

In 2017 there were 28,170 deaths were caused by lung cancer in England, compared to 28,546 in 2016 and 28,849 in 2014. For patients diagnosed 2012-16, the one-year survival figure is 39.6% in England, compared 37.0% for patients diagnosed 2010-2014.

Recent data had suggested that 5-year survival was improving, partly explained by higher surgical resection rates. However, the covid-19 pandemic has set lung cancer outcomes back 10 years with the surgical resection rate for non-small cell lung cancer in GM falling from 19% in 2019 to 12% in 2020.

Survival rates in the UK have consistently been shown to be below many other western countries and there is evidence to suggest that this is likely to be the result of both late presentation and/or late referral to specialist care and under treatment. An international study of lung cancer patients based upon tumours diagnosed between 1990 and 2000 showed that a large variation exists in survival for non-small cell lung cancer (NSCLC) by stage. It also showed patients diagnosed with very early stage disease who are surgically treated had an overall five-year survival of 73%. It has been estimated that at least 1,300 lives could be saved per year if our survival rates were as good as the best in Europe.

Lung cancer is the leading cause of cancer mortality in England and the world. This is because it is common and the majority of people with lung cancer present late when treatment has a limited effect on mortality. People in the most deprived socioeconomic quintile are twice as likely to develop lung cancer as those in the most affluent although there are still around 5500 people diagnosed each year in the latter group.

The diagnosis, staging, fitness assessment, co-morbidity and health optimisation (including the treatment of tobacco dependency), treatment and supportive / palliative care of lung cancer are complex and require specialist expertise that is not always available in every hospital or region.

There is marked variation in treatment rates in both England and Greater Manchester. This variation is associated with marked differences in outcomes. In Greater Manchester the median overall survival in patients with lung cancer in 2019 was 330 days (National Lung cancer Audit 2022) but there was variation in overall

survival across the different localities with the lowest overall survival (176 days) less than half that of the highest overall survival (407 days). Shorter diagnostic pathways are associated with a significant improvement in long term survival confirmed in both randomized controlled trials and meta-analysis. It is important that all people have equal access to the best treatment rates if we are to achieve the outcomes seen in other European countries.

Lung cancer is classified into non-small cell lung cancer (NSCLC) accounting for the majority of cases, and small cell lung cancer (SCLC) accounting for approximately 10%. NSCLC has two major sub-types; squamous cell carcinoma and adenocarcinoma. Early-stage lung cancer (Stage I/II) are managed with local therapies (surgical resection or curative intent radiotherapy). Advanced stage disease (stage IV) is managed with systemic anti-cancer therapy (SACT) with the aim of disease control not cure. SACT is a rapidly expanding field with a number of treatment options personalized to the immune-genetic profile of the tumour including, chemotherapy, immunotherapy, combination chemotherapy-immunotherapy and targeted treatment such as tyrosine kinase inhibitors. Locally advanced lung cancer (Stage III) requires multi-modality treatment that combines local and systemic therapies. SCLC is generally a more aggressive tumour requiring rapid diagnosis and treatment with chemotherapy being the central treatment modality alongside radiotherapy and, increasingly, immunotherapy.

This document draws its evidence and rationale from a range of documents as listed below. These documents will provide additional information regarding the diagnosis, staging & management of lung cancer.

- NICE Lung Cancer Diagnosis & Management Guidelines NG122 2019[1]
- NICE Lung Cancer Quality Standards[2]
- Quality Surveillance Measure for Lung Cancer Multi-Disciplinary Teams
- National Lung Cancer Getting It Right First Time (GIRFT) Report 2022
- National Lung Cancer Audit Report 2022
- National Lung Cancer Optimal Pathway - NLCOP (Lung Cancer Clinical Expert Group)
- National Diagnostic Standards of Care (Lung Cancer Clinical Expert Group)
- National EBUS Service Specification (Lung Cancer Clinical Expert Group)[3]

1.1 Greater Manchester Context and Evidence

The crude incidence rate in Greater Manchester in 2017 was 118.4 per 100,000 population in males and 100.9 per 100,000 population in females. There were 2519 and 2326 newly diagnosed cases of lung cancer in Greater Manchester in

[1] https://www.nice.org.uk/guidance/ng122

[2] https://www.nice.org.uk/guidance/qs17/resources/lung-cancer-in-adults-pdf-2098490350021

[3] NHSE-EBUS-Service-Specification-Final-Oct-19DRB.pdf (roycastle.org)

2017/2018. The age standardised mortality rate for lung cancer in GM is 75.3 per 100,000 population, compared to the England average of 55.9.

Greater Manchester Lung Cancer New Diagnoses

CCG	2016	2017	2018
Bolton	236	215	214
Bury	167	153	156
HMR	205	228	178
Manchester	445	463	392
Oldham	196	211	204
Salford	253	234	228
Stockport	221	253	232
Tameside	271	253	248
Trafford	199	204	166
Wigan	312	305	308
GM TOTAL	**2505**	**2519**	**2326**

Greater Manchester Stage at Diagnosis (Lung Cancer)

Stage	1	2	3	4	NK
2016	24.9%	9.2%	19.3%	42.4%	4.2%
2017	26.9%	9.1%	17.8%	42.1%	4.0%
2018	24.8%	8.2%	22.3%	41.7%	5.0%

Commissioning of services that currently achieve the best outcomes in England would be expected to result in a significant improvement in these survival rates as well as improving symptom control and experience of care for patients. Thus, the national emphasis should be to reduce variation by ensuring all services achieve the standards achieved by the best (and the best improve further).

The local commissioning structures offered flexibility but have the potential to increase variation if evidence-based standards for services are not applied across Greater Manchester. National guidance should be followed, and local flexibility employed to implement the guidance within the local healthcare landscape in order to meet the GM standards for lung cancer and deliver the model of care.

In addition to the national guidance listed above, this document also draws evidence from the GM Lung Cancer Document Library:

GM Front End of the Lung Cancer Pathway Documents

- GM Lung Cancer Diagnostic Algorithms
- GM strategy for promoting earlier diagnosis & better outcomes in symptomatic lung cancer: getting the front end of the pathway right
- GMMMG Medical Management of Tobacco Dependency Protocol

GM Diagnostic Pathway in Lung Cancer Documents

- GM strategy for delivering an accelerated lung cancer diagnostic & staging lung cancer pathway
- GM Reflex testing in NSCLC Protocol
- GM Lung Cancer MDT Charter

GM Lung Cancer Treatment Documents

- GM Emergency Pathways in Lung Cancer (including referral forms for new diagnosis of SCLC & Emergency admission to Wythenshawe hospital)
- GM One-stop lung cancer clinic overview & process map
- GM NSCLC N2 Trimodality Protocol
- GM Lung Cancer Referrals Standard Operating Procedure

GM Lung Cancer Survivorship Documents

- LNC-PATH protocol for risk stratified follow-up after curative intent treatment for lung cancer in GM
- ASSENT & STEPS protocol for risk stratified follow-up after curative intent radiotherapy for lung cancer

Providers are asked to maintain assurance and competence of practitioners for all aspects of the lung cancer pathway

2. Outcomes

2.1. NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill-health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating & caring for people in a safe environment, protecting them from avoidable harm

2.2 GM Lung Cancer Alliance Senior Leadership Team, Performance Director & Pathway Board Aims:

1. Achieve / exceed the NHS England 62-day pathway target
2. Achieve / exceed the 28-day Faster Diagnosis standard across GM
3. Deliver the National Lung Cancer Optimal Pathway across the entirety of GM (49-day referral/upgrade to treatment pathway)
4. Deliver the components of the NLCOP & deliver all GIRFT recommendations including:
    - Referral/upgrade to MDT of 21 days
    - Decision to treat to surgery 21 days
    - Decision to treat to radiotherapy 16 days
    - Decision to treat to SACT 14 days

2.3 GM Outcome Measures:

Description	Current performance	Target 2023/
Proportion of patients discussed in treatment decision MDT by day 21	2021 (GM Tableau) 37% 2WW 66% Upgrades	≥85%
Overall curative-intent treatment rate in patients with NSCLC stages I-II & PS 0-2	2019 (NLCA): 83% 2020 (NLCA): 74%	≥85%
Proportion of patients with NSCLC undergoing surgery	2019 (NLCA): 19% 2020 (NLCA): 12%	≥20%
Proportion of patients with advanced stage NSCLC (Stage IV) PS 0-1	2019 (NLCA): 50% 2020 (NLCA): 48%	≥70%
Proportion of patients with SCLC receiving chemotherapy	2019 (NLCA): 61% 2020 (NLCA): 66%	≥70%
Proportion of patients with SCLC receiving treatment within 14 days of pathological diagnosis	2019 (NLCA): 20% 2020 (NLCA): 14%	≥80%

Proportion of patients undergoing surgery within 21 days from decision to treat (DTT)	2021 (GM Tableau) 67% 2WW 78% Upgrades	≥85%
Proportion of patients undergoing radiotherapy within 16 days from decision to treat (DTT)	2021 (GM Tableau) 50% 2WW 39% Upgrades	≥85%
Proportion of patients undergoing SACT within 14 days from decision to treat (DTT)	2021 (GM Tableau) 84% 2WW 78% Upgrades	≥85%
Proportion of patients accessing first treatment by day 49 (National optimal pathway)	2021 (GM Tableau) 41% 2WW 56% Upgrades	>75%
Proportion of patients accessing first treatment by day 62 (cancer waiting times standard)	2021 (GM Tableau) 63% 2WW 71% Upgrades	≥85%
Proportion of patients informed whether they have cancer by day 28 (Faster Diagnostic Standard)	-	≥75%

3. Delivery of the GM Lung cancer Outcomes

The purpose of a secondary care lung cancer service is to deliver rapid and accurate diagnosis, staging and physiological assessment that supports high quality evidenced-based treatment recommendations within a multi-disciplinary team meeting. During this process all lung cancer services must ensure high quality and effective co-morbidity assessment and optimisation. This includes comprehensive treatment of tobacco dependency, malnutrition screening & management, referral of all eligible patients to the GM prehab4cancer programme and the identification and management of frailty. Effective treatment is delivered by tertiary treatment services (thoracis surgery by Manchester University NHS Foundation Trust and oncology treatment by The Christie NHS Foundation Trust). Survivorship and risk-stratified follow-up after treatment is developed via standardised protocols in GM and across treatment teams and at the local secondary care provider. There are different components of the lung cancer pathway lead by different teams across Greater Manchester with the responsibility of performance resting with primary care, individual trusts and at a regional level with the cancer alliance for different components of the pathway. To deliver the lung cancer outcomes described in this model of care the a number of key performance indicators must be attained through appropriate commissioning &

pathway improvement work across the different organisations involved in delivering lung cancer care.

Primary Care

Primary care teams/networks are a diverse medical workforce including General Practitioners, practice nurses, specialist nurses, physician associates, pharmacists and other allied health professionals. Primary care plays a pivotal role in earlier diagnosis of lung cancer and driving improvements in lung cancer outcomes. The key focus for primary care is increase the volume of Chest X-rays in patients with persistent chest symptoms and increase the number of referrals for suspected lung cancer, both of which have been shown to improve earlier diagnosis.

Primary care teams will be commissioned and supported to deliver the following targets:

Description	Responsibility	Target for 2023/2024
A rolling training programme to ensure all AHPs can request Chest X-rays	Primary care networks and GP practices	>75% practices compliant
CXR rate per GP practice/primary care network of ≥34 per 1000 patients	Primary care networks and GP practices	>75% practices/PCNs compliant
A rolling programme of primary care education on earlier diagnosis of lung cancer	GM Cancer & Gateway C	100% compliance – accessible to all PCNs in GM
A rolling programme of public awareness campaigns on earlier diagnosis in lung cancer	GM Cancer & Primary care networks	100% compliance – visibility in all PCNs in GM
Provision of a 'Direct access GP CXR: walk in' service for all patients	Secondary care provider & PCNs	100% compliance – accessible to all patients across GM

Secondary Care Lung Cancer Team

Trust lung cancer teams are multi-disciplinary teams including:

- Respiratory / lung cancer physicians
- Lung Cancer Nurse Specialists
- Thoracic radiologists
- Thoracic pathologists
- Tobacco dependency practitioners

Secondary care lung cancer teams will be commissioned and supported to deliver the following targets (all days are calendar days):

Description	Standard	Target 2023/34
Delivery of a Direct access GP CXR: walk in' service for all patients	Compliant	Compliant
Reporting of GP requested Chest X-rays within 24 hours of completion	≤24 hours	≥85%
'Direct to CT pathway' that delivers a pathway of abnormal CXR to reported CT of 72 hours (pathway starts from date of CXR)	≤72 hours	≥85%
2WW referral to reported CT pathway of 72 hours	≤72 hours	≥85%
Lung cancer clinician time is job-planned everyday Monday-Friday to provide daily triage of referrals, CT results and to include virtual board round of every patient on the cancer pathway to review test results (recommended 4 hours, 1xPA per day)	Compliant	Compliant
CT report (from 2WW referral/direct to CT pathways) to lung cancer clinician triage ≤24 hours	≤24 hours	≥85%
Provision of lung function (Spirometry, diffusion studies) and functional exercise test (shuttle walk test / 6-min walk test) for patients on the lung cancer pathway within 5 days from request	≤5 days	≥85%
Provision of echocardiogram for patients on the lung cancer pathway within 5 days from request	≤5 days	≥85%
Provision of brain imaging for patients with stage II/III lung cancer (contrast enhanced CT brain/contrast enhanced MR brain) for patients on the lung cancer pathway within 5 days from request	≤5 days	≥85%
Provision of basic cancer diagnostics (bronchoscopy, pleural aspiration, USS guided biopsy) for patients on the lung cancer pathway within 5 days from request	≤5 days	≥85%
Compliance with the GM Reflex Testing in NSCLC protocol with 90% of eligible specimens sent for reflex testing	≥90%	≥90%
Ensure biopsy results (morphology and up to 4 panel IHC are available within 3 days of procedure for suspected lung cancer samples	≤72hrs	≥85%
Ensure patients with lung cancer have a treatment decision MDT discussion within 21 days of referral or upgrade to the lung cancer pathway	≤21days	≥85%
Ensure patients are informed of the MDT outcome & referrals made to the relevant treatment teams within 24 hours of MDT discussion.	≤24 hours	≥85%
Ensure patients eligible for prehab4cancer are identified within the lung cancer MDT, that prehab4cancer is recorded as part of the management	≥90% eligible patients referred	≥90% eligible patients referred

plan within the MDT documentation and patients are referred to the programme		
Ensure all clinicians in the lung cancer team have completed training in the management of tobacco dependency (NCSCT training, RCP e-learning module)	100% of patient-facing clinicians	100% of patient-facing clinicians
Ensure access to all evidence-based tobacco dependency interventions are available for patients on the lung cancer pathway including tobacco dependency practitioners and pharmacotherapy	Compliant	Compliant
Refer patient for lung cancer treatment with complete referral data in line with the GM Lung Cancer Referral SOP	Compliant	>90% of referrals compliant with SOP
Delivery risk stratified follow-up after lung cancer surgery in line with the GM LNC-PATH protocol	Compliant	Compliant
Delivery risk stratified follow-up after curative-intent radiotherapy in line with the GM ASSENT/STEPS protocol	Compliant	Compliant

Specialist cancer diagnostics

Specialist lung cancer diagnostics are key diagnostic tests that are not available in every hospital. The operational oversight and performance management does not, therefore, rest with the individual secondary care providers. This responsibility will sit across the providers of these tests and the cancer alliance. Greater Manchester Cancer will ensure the following performance metrics for specialist cancer diagnostics (all days are calendar days):

Description	Standard	Target 2023/34
Provision of PET-CT for patients on the lung cancer pathway within 5 days from request	≤5 days	≥85%
Provision of EBUS-TBNA for patients on the lung cancer pathway within 5 days from request	≤5 days	≥85%
Provision of CT-guided lug biopsy for patients on the lung cancer pathway within 5 days from request	≤5 days	≥85%
Provision of specialist pleural diagnostics (medical thoracoscopy, VATS) for patients on the lung cancer pathway within 5 days from request	≤5 days	≥85%
Provision of full predictive marker testing for NSCLC within 10 days of biopsy procedure	≤10 days	≥85%

Tertiary Care Lung Cancer Treatment teams

Tertiary treatment teams include thoracic surgery (delivered at a single site at Wythenshawe Hospital, Manchester University NHS Foundation Trust), clinical oncology & medical oncology delivered by The Christie NHS Foundation Trust

(curative-intent radiotherapy including SABR, adjuvant therapies, palliative SACT with some delivered closer to home at satellite units) and thermo-ablative services (delivered at Manchester Royal Infirmary, Manchester University NHS Foundation Trust). Tertiary care lung cancer teams will be commissioned and supported to deliver the following targets (all days are calendar days):

Description	Standard	Target 2023/34
Ensure patients are reviewed by a lung cancer treatment team and receive a decision to treat within 7 days of receiving a complete referral (in line with GM Lung Cancer Referral SOP). Utilise one-stop/joint clinics to deliver this where needed	≤7 days	≥85%
Ensure adequate capacity and processes (e.g. pooling/sharing of referrals to next available consultant) to deliver the required DTT to treatment pathway (surgery = 21 days, XRT = 16 days, SACT = 14 days)	Surgery ≤21 days XRT ≤16 days SACT ≤14 days RFA ≤14 days	≥85%
Patients with small cell lung cancer start treatment within 14 days of a pathological diagnosis	≤14 days	≥80%
Provide a second opportunity for prehab4cancer referral - Ensure all patients are screened for eligibility for prehab4cancer and refer patients not yet referred by local secondary care team	≥90% eligible patients referred	≥90% eligible patients referred
Provide a second opportunity to identify and treat tobacco dependency - ensure access to all evidence-based tobacco dependency interventions are available for patients on the lung cancer pathway including tobacco dependency practitioners and pharmacotherapy	Compliant	Compliant
Ensure patients aged >65 are screened for frailty with clinical frailty score (CFS) and offered oncogeriatric assessment / comprehensive geriatric assessment to support frailty when indicated (CFS ≥5).	≥90% patients screened with CFS ≥90% of CFS ≥5 completing CGA	≥90% patients screened ≥90% completing CGA
All patients are discussed, assessed & optimised for optimal adjuvant treatment following curative-intent treatment through appropriate mechanisms (e.g. post-treatment MDTs) with uptake optimised (e.g. through treatment at home). Rates of adjuvant treatment should be published annually.	Compliant	Compliant

Essential Infrastructure for secondary care providers:

- One WTE respiratory physician direct clinical care (10 Pas DCC) per 200 new diagnoses per year.
- Radiologists with at least a third of their job plan devoted to thoracic imaging direct clinical care
- Medical and clinical oncologists with at least one third of their job plan devoted to lung cancer direct clinical care.
- One WTE LCNS per 80 new diagnoses per year
- Specialist supportive / palliative care services
- Specialist pulmonary pathologists
- Direct to CT pathways
- Separate diagnostic planning process or MDT from treatment MDT meetings
- Bronchoscopy
- Pleural aspiration service
- USS guided biopsy service (easily accessible sites for biopsy e.g. supraclavicular lymph node)
- Lung function and functional testing with Incremental shuttle walk / 6-min walk test
- Echocardiogram
- Contract enhanced brain imaging (CT and MR)
- Tobacco dependency treatment service
- Palliative care service

Regional services:

- PET-CT
- EBUS-TBNA
- CT-guided lung biopsy
- Prehb4cancer programme
- Oncogeriatrics for frailty management in lung cancer
- Thoracic surgery
- Clinical oncology including SABR
- Thermo-ablative service
- Medical oncology service (adjuvant and palliative services)

Reducing Variation in the Diagnostic Pathway – GM Best Timed Pathway for Lung Cancer

Access to CT scan

- Patients referred from primary care on the 2WW suspected lung cancer pathway should complete a CT scan and the CT be reported within 72 hours of referral. Similarly, patients with an abnormal CXR suspicious of lung cancer should complete a CT scan and the CT be reported within 72 hours.

Expert Triage of CT reports

- Results of CT scans performed for suspected lung cancer should be triaged by a clinician with appropriate expertise within 24 hours of the CT report

being available. This triage will be available daily Monday-Friday at all secondary care services.

- This triage will allow identification of probable lung cancer cases and the ability to discharge or complete an onward referral to the appropriate team for non-cancer cases.
- For cases of suspected lung cancer the appropriate diagnostic, staging and physiological investigations can be planned as 'diagnostic bundles' in line with National Diagnostic Standards of Care and the GM Lung Cancer Diagnostic Algorithms.
- The identification of co-morbidities that can be optimised including the treatment of tobacco dependency is an important part of this process
- A process for consulting with the patient to ensure they are fully informed of the need for further diagnostic tests is required and can be either face-to-face or over the telephone and can be delivered by an appropriate member of the lung cancer team.

Diagnosis, Staging and Assessment of Fitness

- All services will have prompt access to **local cancer diagnostics** and **specialist cancer diagnostics**

Investigation	Target 2022 onwards
PET-CT	≤5 days
Endobronchial ultrasound (EBUS)	≤5 days
CT-guided lung biopsy	≤5 days
Thoracoscopy	≤5 days
specialist predictive marker testing NSCLC	≤10 days
Lung function (spirometry/DLCO) and functional testing (ISWT/6MWT)	≤5 days
Echocardiogram	≤5 days
Contrast enhanced brain imaging (CT/MR)	≤5 days
Bronchoscopy	≤5 days
Pleural aspiration	≤5 days
USS-guided biopsy	≤5 days
Thoracic pathology (morphology and up to 4-panel IHC	≤3 days

- All services will have a reflex testing pathology protocol for lung cancer cases which will minimise any delay to full pathology report **(target 90% of specimens eligible are sent for reflex testing).**
- All services will deliver daily clinical review of all cases undergoing lung cancer diagnostics to ensure results are acknowledged and acted on the same day as they become available. This process must be included in relevant clinicians' job plans **(this plus the referral/CT process should make up 1xPA / 4hrs per work of job planned time per day).**

Audits

Lung cancer services – both secondary care and tertiary care teams will uptake regular audits to assess compliance with the model of care set out in this model of care. This can be supported by the GM Tableau system which will live pathway data including milestone waits through the pathway. Specific audits will also be completed on the following areas:

Compliance with GM Reflex testing for NSCLC protocol
Referral to prehab4cancer
Compliance with GM Lung cancer Referral SOP
Compliance with the GMMMG treatment of tobacco dependency protocol
Personalised Care including Stratified Follow up

Services must ensure that people have the same access to care that improves aspects of living with and beyond cancer, specifically:

- People with known or suspected lung cancer have access to a named lung cancer nurse specialist who they can contact between scheduled hospital visits
- People with lung cancer are offered a holistic needs assessment at each key stage of care that informs their care plan and the need for referral to other services
- To ensure this is possible there should be a minimum of 1 WTE LCNS per 80 new patients per year.
- People with known or suspected lung cancer should have information about their disease and options for treatment presented to them in a format they can understand, to enable them to make an informed choice.
- Excellent communication between professionals and patients is particularly important and can avoid complaints and improve patient satisfaction
- Prehab4cancer offers both prehabilitation prior to treatment and 12 weeks rehabilitation following treatment including nutritional and well-being support. This highlights the importance of referral of all eligible patients at the point of diagnosis and MDT treatment decision.
- People with lung cancer are offered care integrated across primary and secondary care with liaison coordinated through specialist nursing teams.
- People with lung cancer are offered a specialist follow-up appointment within 6 weeks of completing initial treatment and regular specialist follow-up thereafter, which can include protocol-led clinical nurse specialist follow-up
- The LNC-PATH and ASSESNT/STEPS protocols should be followed to provide risk stratified follow up after surgery and curative-intent radiotherapy respectively.
- Key interventions recommended in “Living with and beyond cancer: taking action to improve outcomes”: Structured Holistic Needs Assessment and care planning, Treatment Summaries, Patient education and support events (Health and Wellbeing Clinics);
- People with stage IV (advanced, incurable disease), irrespective of other treatments options offered, should be routinely offered a specialist supportive / palliative care assessment at the time of diagnosis.

Treatment Decision MDT

- All elements of the GM Lung Cancer MDT charter should be implemented including appropriate job planned time for MDT triage and preparation for the MDT chair & quarterly to review operational processes, ways of improving the care delivered and assess adherence to the charter recommendations
- Patients should be routinely discussed at a treatment decision MDT by day 21 of pathway.
- There must be an MDT meeting at least weekly attended (either in person or via good quality videoconference) by the clinicians specified below.
- This provides intra-MDT peer review of real-time clinical opinion.
- Cross cover should be available for all MDT meetings at all times.
- Cross cover should be available for all clinical services at all times.
- Providers across GM should work collaboratively to support active patient pathways and minimise 62d/104d breaches

Treatment decision MDT Membership:
At least one, preferably more, to ensure comprehensive cross-cover of:

- MDT Chair
- MDT Scribe
- Designated respiratory physician
- Designated thoracic surgeon
- Clinical oncologist
- Medical oncologist (some MDTs have this role provided by a second clinical oncologist). A medical oncologist's attendance in addition to a clinical oncologist is recommended.
- Imaging specialist
- Histopathology specialist
- Lung cancer nurse specialist
- Specialist in palliative medicine / care
- MDT co-ordinator/secretary
- An individual responsible for data collection and audit
- An NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers
- A member of the core team nominated as the person responsible for ensuring recruitment into clinical trials and other well-designed studies is integrated into the function of the MDT

MDT to decision to treat

- Patients will only be accepted by the receiving trust (via Cancer Referral Proforma – CaRP) once all diagnostic tests are complete and in time for the results to be available for the MDT meeting (in line with GM Lung Cancer MDT Charter and the GM Lung Cancer Referrals SOP)
- All patients should be informed of their treatment options and referred to appropriate specialist within 24 hours of the treatment decision MDT.
- All referred patients should be offered a clinic appointment with a treating specialist & a decision to treat within 7 calendar days of acceptance of a complete referral (in line with the GM Lung Cancer Referrals SOP).

Treatment with Curative Intent

- Offer treatment with curative intent in line with NICE guidance for all patients who are sufficiently fit.
- Ensure all patients with Stage III N2 disease, considered potentially resectable, are considered for tri-modality treatment (chemoradiotherapy followed by surgery, in line with GM N2 trimodality protocol)
- Ensure all patients who have surgically resectable disease but with borderline fitness are assessed in a combined surgical-oncology clinic to ensure prompt, optimal treatment decision making (in line with GM one-stop lung cancer clinic service overview & process map).
- Ensure patients, with advanced stage disease and those who may be eligible for adjuvant treatments undergo appropriate genetic & molecular testing of cancer tissue to ensure their treatment is personalised to them

Treatment with Palliative Intent

- Offer treatment with palliative intent in line with NICE guidance for all patients who are sufficiently fit.
- People with stage IV (advanced, incurable disease), irrespective of other treatments options offered, should be routinely offered a specialist supportive / palliative care assessment at the time of diagnosis.

Population Covered

Patients registered with an English General Practitioner within the CCGs of Greater Manchester and resident in the European Union and eligible for treatment in the NHS under reciprocal arrangements. Patients from Cheshire may also access services within GM based on agreed pathways and funding arrangements (this will require the Cheshire CCG to adopt this service specification).

Patients from Scotland, Wales and Northern Ireland are not part of this commissioned service and the Trust would need to have separate arrangements in place.

The service is accessible to all patients with a suspected (or confirmed) lung cancer regardless of sex, race, or gender. Providers require staff to attend mandatory training on equality and diversity and the facilities provided offer appropriate disabled access for patients, family and carers. When required the providers will use translators and printed information available in multiple languages.

The provider has a duty to co-operate with the commissioner in undertaking Equality Impact Assessments as a requirement of race, gender, sexual orientation, religion and disability equality legislation

Any acceptance and exclusion criteria and thresholds

Local and specialised services are described in this document. Additional details related to specialised services (thoracic surgery, radiotherapy and systemic anti-cancer therapy) would be found in the relevant service specifications

Payment arrangements

As per agreed arrangements between GM ICS and the acute provider

NHSE/GMHSCP to fund specialist treatment as per current arrangements with tertiary centers (MFT and Christie Hospital)

Staffing Structure

The service must provide the following expert time commitment:

- There must be an equivalent of 1 full time respiratory physician with all of their time (10 direct clinical care PAs) spent in lung cancer per 200 new patients per year. This is the approximate expert time currently commissioned from large centres.
- There must be local provision of first visits with respiratory physicians, with the above expertise and supportive infrastructure. This may mean commissioning these services from the centre where it may be easier to attract doctors with the necessary specialist interest. These clinicians will need to travel to provide services locally.
- There must be access to thoracic radiologists with at least one third of their job plan devoted to thoracic imaging
- There must be access, through the MDT, to medical and clinical oncologists with at least one third of their job plan devoted to lung cancer. These services are also specified in the specialised commissioning service specification for chemotherapy and radiotherapy.
- Patients that may be suitable for surgery but are judged to be at higher risk from surgery require access to a joint surgical and oncology clinic to optimise the efficiency of decision making.
- One WTE LCNS per 80 new diagnoses per year

Complaints

Complaints will be managed by current local arrangements

Interdependencies with Other Services / Providers

Primary care clinicians need easy and rapid access to chest x-rays with a rapid turn round time of reports. Local arrangements should be in place for the identification of abnormal CXR reports combined with mechanisms for rapid referral to specialist lung cancer clinics as per the GM strategy for Earlier Diagnosis in Lung Cancer.

Lung cancer services must make effective links with end of life care services that are provided in line with NICE guidance and in particular the markers of high quality care set out in the NICE Quality Standard for end of life care for adults.

- Engage in a discussion about end of life prior to the terminal stage of illness
- Document these discussions about end of life care

EoLC services that are linked to the lung cancer teams, should provide end of life care in line with the principles set out in the NHSE endorsed End of life guidance that can be found at: www.endoflifecareambitions.org.uk
EoLC services should be integrated and cross primary and secondary care, coordinated through specialist nursing teams, and includes, where appropriate, use of the Hospice service.

4. Applicable Service Standards

4.1. Applicable National Standards

Care delivered by the lung cancer service providers must be of a nature and quality to meet the CQC care standards and the relevant NICE quality standards. The service will also comply with other relevant NICE standards that define best clinical practice.

Imaging and pathology services must be available to the MDT in line with the network agreed guidelines for these services**.** The pathology services should operate as per Royal College of Pathologists' guidelines and standards. Laboratories should comply with Clinical Pathology Accreditation (UK) Ltd (CPA) and participate in appropriate NEQAS modules. Where pathology is available, pathologists should complete the Royal College of Pathologists' minimum dataset for lung cancer for discussion at the lung cancer MDT.

It is the trust's responsibility to notify the commissioner on an exceptional basis should there be any breaches of the care standards. Where there are breaches, any consequences will be deemed as being the trust's responsibility.

Secondary care lung cancer services are required to meet the following standards for all lung cancer patients:

- Referral or abnormal CXR to reported CT of ≤72 hrs (≥85%)
- Referral to treatment MDT ≤21 days (≥85%)
- Referral to diagnosis (faster diagnostic standard) ≤28 days (75%)

Tertiary providers and the cancer alliance are required to meet the following standards

- Treatment referral to decision to treat (DTT) ≤7 days (≥85%)
- DTT to surgery ≤21 days (≥85%)
- DTT to radiotherapy ≤16 days (≥85%)
- DTT to SACT ≤14 days (≥85%)
- Time from pathological diagnosis to treatment in SCLC ≤14 days (≥85%)
- Referral to treatment ≤62 days (≥85%).
- Referral to treatment ≤49 days (≥85%)

Teams should as a minimum aim to achieve the median value for compliance with the Cancer Surveillance quality indicators / CHI measures, and where the team does not achieve remedial action plans should be in place and shared with commissioners in line with the agreed timescales. Further details are available at https://www.qst.england.nhs.uk

The provider must be able to offer patient choice. This will be both in the context of appointment time and for diagnostic/treatment options, including those not available locally

4.2 Safe Staffing

The Provider(s) will ensure that staffing levels across the service are adequate to manage the delivery of care. This will include adherence to national or local

guidance on safe staffing and any current or future requirement to publish staffing levels.

4.3 Clinical Effectiveness

The Provider(s) where required will employ models of care, interventions and treatments that are evidence based e.g. Royal College Standards, NICE guidance.

The Provider(s) will be required to use technology, clinical audit, data management and analysis, service reviews, intelligence and other techniques to evaluate its effectiveness and to drive continuous service improvement.

The Provider(s) will be required to participate in properly conducted quality research where possible (with appropriate ethical approval).

4.4 Safeguarding

The Provider(s) will have clear protocols and policies in place to ensure that local safeguarding procedures are an integral part of the service delivery to ensure in particular the Protection of Vulnerable Adults but also extending to the protection of Children.

The Provider(s) will be required to ensure that all staff are appropriately trained in local safeguarding procedures and maintain these competencies, to ensure that staff are appropriately supported to implement safeguarding procedures where concerns have been identified. All staff working with Vulnerable Adults will have undertaken a Disclosure and Barring check.

The Provider(s) will be required to ensure that protocols and policies are in place to ensure compliance with current and future National guidance and legislation (e.g. Mental Capacity Act (2005), Deprivation of Liberty Safeguards).

4.5 Risk Management

The Provider to establish operational management and governance structures that will enable effective issue escalation in order to enable the team to manage risk.

4.10 Clinical Audit

Providers should contribute to national & local audits relating to the safe and effective delivery of services for patients with suspected or diagnosed lung cancer

4.11 Reporting and Monitoring

The GM Tableau system provides a live dashboard for these performance measures and provides hospital teams with the ability to monitor pathways in real-time.

4.12 Incident Reporting

To follow national requirements including NHS Serious Incident reporting.

5. Outcomes and Performance Management

5.1. Measuring Outcomes and Key Performance Indicators

Pathway outcomes for all providers should be visible on the Lung Best Timed Pathway Dashboard & GIRFT dashboard via GM Tableau.
https://www.gmtableau.nhs.uk/#/site/GMHSCPPublic/workbooks/3750/views

Health Inequalities information should also be collected routinely and available on request, to ensure that patients from protected groups are accessing the same levels of service and outcomes are comparable.

5.2. Data Collection & Audit

Services must comply with the collection of the mandatory Cancer Services and Outcomes Dataset (COSD) and SACT (Systemic Anti-Cancer Therapy) dataset. *If the service is a provider of radiotherapy it must also comply with the collection the RTDS (Radiotherapy Dataset).*

The care of patients should be regularly audited locally to supplement nationally collected data, where necessary.

- The MDT should participate in the National Lung Cancer Audit, network-wide audit of lung services and the National Cancer Surveillance programme.
- Thoracic surgical services should validate their data as required by the Lung Cancer Clinical Outcomes Project (LCCOP).
- EBUS performance data collection & submission
- Quality Assurance monitoring for all pathology turnaround and molecular profiling
- Compliance with GM Reflex testing for NSCLC protocol
- Referral to prehab4cancer
- Compliance with GM Lung cancer Referral SOP
- Compliance with the GMMMG treatment of tobacco dependency protocol

5.3 Service Improvement, Innovation & Review

There must be support from each local service for data collection to inform local and national service development

6. Location of Provider Premises

Expected referral pathways are described below based on current commissioning arrangements. It is accepted that patients can choose another provider

Referral Pathways:

Greater Manchester CCGs / Localities	Local Lung Team
NHS Bolton CCG	Royal Bolton Hospital Foundation Trust
NHS Bury CCG	Pennine Acute Hospitals NHS Trust
NHS Heywood Middleton & Rochdale CCG	Pennine Acute Hospitals NHS Trust

NHS Manchester CCG	Manchester University NHS Foundation Trust
NHS Oldham CCG	Pennine Acute Hospitals NHS Trust
NHS Salford CCG	Salford Royal Foundation Trust
NHS Stockport CCG	Stockport NHS Trust
NHS Tameside & Glossop CCG	Tameside & Glossop Integrated Care Foundation Trust
NHS Trafford CCG	Manchester University NHS Foundation Trust
NHS Wigan CCG	Wrightington Wigan & Leigh NHS Foundation Trust
NHS Cheshire CCG	East Cheshire NHS Foundation Trust, Mid Cheshire NHS Foundation Trust

Specialist Treatment Providers & Location:

Thoracic Surgery	Manchester University NHS Foundation Trust
Systemic Anti-Cancer Therapy	Christie Hospital NHS Foundation Trust
Radiotherapy	Christie Hospital NHS Foundation Trust
Thermo-ablative service	Manchester University NHS Foundation Trust

Cancer Operational Performance and Recovery
20 June 2022

Title of paper:	**Cancer Operational Performance & Recovery** Incorporates: Best practice timed pathway compliance; referral, RTT and conversion rate correlation, P2 cancer surgery recovery modelling and an oversight framework
Purpose of the paper:	To advise the GM Cancer Board of the current operational performance within Cancer, along with current and proposed actions to aid recovery
Summary outline of main points / highlights / issues	• Current operational trajectories • Demand • Diagnostic waiting times in line with the national Best Practice Timed Pathways • Timely access to specialist and staging diagnostics • Surgical treatment volumes and compliance with the 4 week (28 day) clinical criteria • Cross cutting and tumour specific improvements • Recovery oversight • Conclusion and summary of new actions for agreement **<u>Key areas for action:</u>** 1. Increase surgical treatment volumes to 310 weekly (current increase 60 per week average) including use of mutual aid 2. Increase the first line diagnostic capacity dedicated to cancer to deliver compliance with the Best Practice Timed Pathways (BPTP) 3. Approval of Recovery Panel ToR
Consulted	This entire paper has been presented to Gold Command, Comminity Co-Ordination Cell and was approved at the Provider Federation Board. Individual aspects were presented at Executive Medical Directors Forum, Chief Operating Officers Forum and Director of Strategy Forum prior to this paper being produced and approved.
Author of paper and contact details	**Name:** Lisa Galligan-Dawson **Title:** Performance Director, GM Cancer **Email:** lisa.galligan-dawson@nhs.net

Contents

1. Introduction & Context

It is well documented that delays in diagnosing and treating cancer results in poor physical outcomes (Neal et al, 2015), as well as having a psychological impact on patients (Miles, 2018). The NHS constitutional standards for Cancer Waiting Times (CWT) are intended as quality markers and to deliver cancer care in clinically appropriate timescales.

There are 9 Aspects to the constitutional standards. The delivery of the 62-day referral to treatment standard is seen as the primary indicator. These standards have not been achieved nationally for 9 years (NHS England, 2022) and in GM since Q3 2017/18, with the waiting times for both the diagnostic and treatment elements longer than the expected timeframes. These waiting times have been exacerbated by the Covid-19 pandemic.

In addition to the national standards challenges, unacceptably high waiting lists for both diagnostics and surgery have developed following the Covid-19 pandemic, which must be addressed as a priority in the recovery of cancer services.

The cancer waiting times standards are reported as an aggregate position by organisation, which overlooks key elements of pathway waits including variation and performance at tumour site level. Performance breaches and compliance are allocated to a maximum of two organisations; often pathways include up to four organisations, thus not reflecting the full pathway components. Recovery initiatives must therefore be designed to focus on improving pathways across the entire system,

using key milestones which make up the dis-aggregated data as opposed to focusing solely on the reported performance.

This paper provides a comprehensive overview of the current cancer performance in Greater Manchester (GM), an overview of the system recovery expectations outlined in the 22/23 national planning guidance, along with the requirements outlined in the national Cancer Alliance planning deliverables related to operational performance. The paper consolidates the vast range of improvement initiatives already deployed as well as crystalising the additional system requirements.

2. 22/23 Operational Deliverables

There are three metrics in the 22/23 system planning return specific to cancer.

1. To return the backlog (volume of patients over 62 days from a 2ww referral source on the live PTL) to pre-pandemic level
2. To address the gap in first definitive treatments
3. To deliver the national 28-day FDS standard

There is a plethora of measured improvement required by the national Cancer Programme. The following relate to cancer pathways from the point of referral to treatment only:

1. Improve performance against the three main cancer standards
    - 31-day treatment (First Treatment, Subsequent Surgery, Subsequent Drugs & Subsequent Radiotherapy)

- 62-day urgent referral to first treatment (Urgent GP, Urgent Screening and Consultant Upgrade)
- Faster Diagnosis Standard (FDS)

2. Accelerate roll-out of non-site specific (NSS) pathways. Trajectory to be set and agreed nationally

3. Best practice timed pathway (BPTP) delivery. Milestone measurements against existing pathways, and associated CQUIN
    - Prostate
    - Lung
    - Colorectal
    - Oesophageal

4. Deliver & embed three new BPTP
    - Gynaecology
    - Skin
    - Head & Neck

5. Continue to extend the provision of tele dermatology services and community spot clinics

6. Ensuring effective primary care referral management monitored by the percentage of GP Practices using Clinical Decision Support Tools

7. National innovation initiatives: FIT Testing, Cytosponge, Colon Capsule Endoscopy

8. Reduce variation in treatment across the pathway – responding to highest impact actions from GIRFT and Audit – commencing with Lung.

3. Current Operational Trajectories

22/23 System Planning Requirements

Backlog Reduction (target 761)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	1267	1664	1627	1419	1199	1075	1043	1017	915	777	654	534

First Definative Treatments (target 17000)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	1292	1402	1326	1386	1432	1462	1375	1465	1323	1399	1320	1513

Faster Diagnosis Standard (target 75%)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	7673	8520	8145	8528	9181	8736	9852	9535	9053	10051	9647	10289
	12719	14175	12834	13162	14239	13128	14435	13544	12619	14054	13066	13667
	60.33	60.11	63.46	64.79	64.48	66.54	68.25	70.40	71.74	71.52	73.83	75.28

CWT Improvement Trajectories

Target	Q1	Q2	Q3	Q4
31 day DTT (target 96%)	94%	96%	96%	96%
31 day subsequent surgery (target 94%)	92%	94%	94%	94%
62 day RTT Screenin (target 90%)	68%	68%	70%	70%
62 day RTT Consultant Upgrades (target 85%)	75%	75%	76%	78%
62 day RTT Pure (2ww)	Nil Improvement on baseline 55%			

Other

Other	Q1	Q2	Q3	Q4
NSS Pathway Referrals	825	975	1050	1050
Colorectal BPTP milestone complaince	30%	30%	50%	65%
Prostate BPTP milestone compliance	30%	30%	50%	65%
Lung BPTP milestone complaince	30%	30%	50%	65%
OG BPTP milestone complinace	30%	30%	50%	65%
H&N BPTP - Live				Launch
Gynaecology BPTP - Live				Launch

The 22/23 system (refreshed in June 2022) and cancer alliance planning trajectories will form the basis for reporting and monitoring.

CWT official data on FDS, treatment and performance metrics will not be available until August 2022 as a result of the NCA IT incident. Shadow reporting will be created using best endeavours from the tableau data. It is estimated that the FDS position for April is 60.55% which is in line with the trajectory as a percentage. However, referrals are higher than predicted, but the FDS denominator is around 1000 less than forecasted. This indicates there are patients whose data has not been included because the outcome is unknown at 28 days. As this data is entered it will reduce performance in a future month. Therefore, it is imperative that there is equal focus to the denominator as well as the percentage.

Presently there isn't a local or national reporting framework for BPTP. Local dataflows are being established for automated reporting from Q2. Manual data comparison will be made available for Q1.

4. Demand

One of the key aims of the national cancer team and NHSE was to recover the volume of referrals deemed as 'missing' during the early part of the pandemic. At aggregate level this has been achieved, and over performance has been recognised in most providers, in a number of key specialities. Recovery has not been equal between organisations, localities or tumour sites. It is unknown if this reflects a longer term change in referral patterns.

Considering usual growth would expect to be at 115% pre-covid levels, moving to 120-125% in 22/23. Some specialties have seen activity over 135%.

Focussed work is underway on the quality of referrals. This is led by the Director of Commissioning and Early Diagnosis at GM Cancer Alliance.

Key actions relating to demand:

- Weekly reporting by GP practice and PCN. Reviews of step down at first attendance rates, conversion rates etc.
- GP education and engagement initiatives
- Dedicated cancer lead clinician in each PCN
- Use of filter tests – FIT, dermatascope
- Breast mastalgia pathway development

It is recognised that the wait for routine (and urgent, but non cancer) pathways has increased in many areas. There can be some correlation brought from comparison between 18 week waiting times and conversion rates in some providers and tumour sites, but not all. See APPENDIX 1

It is recommended that urgent capacity is made available to GPs in these key areas to help manage 2ww demand.

5. Access to diagnostic capacity in line with the national Best Practice Timed Pathways

Access to timely first line investigations (and subsequent reporting) is essential in delivering the Faster Diagnosis standard, the BPTP, reducing the backlog and delivering the constitutional cancer waiting times. Furthermore, from the point of diagnosis onwards additional staging and specialist diagnostics remain a significant factor. Diagnostics remains the biggest risk to delivery of cancer improvement. standards.

Key actions relating to diagnostics include:

- Gap analysis on compliance with existing Best Practice Timed Pathways (4)
- Focussed work with imaging network to 1) increase capacity 2) increase reporting capacity 3) provide mutual aid / shared capacity & reporting
- Increase capacity through CDC
- Pathology network support requested to assess options to increase cancer capacity
- Single queue pilot to be progressed to procurement Board and full business case and roll out at pace across GM (finance to be secured)
- PET expansion proposal to be implemented
- Mutual aid and transfer of inpatient bed use for Interventional Radiology (IR) to outpatient

There is currently no formal BPTP reporting (or associated CQUIN). However, an assessment has been made with organisations against the key pathway milestones. The variation in waiting time is shown alongside the day in the patient pathway that

the BPTP expects the diagnostic to be completed. In some diagnostics the wait is almost 200% over the best practice pathway. A full overview by Trust can be found in APPENDIX 2

Lung BPTP variation summary

CT (D3)	Taking 7-15 days for the test
Clinic with report (D6)	Taking 2-5 days for report / clinic
PET CT and report (D14)	Should have PET completed and reported by Day 14 in pathway. PET taking 10 -19 days to complete
Echo / Lung function etc (D14)	Should be completed by Day 14. Takes between 4-12 days
EBUS and report(Day 21)	Takes 10 – 21 days (mainly wait for histology)
CTGBX and report (Day 21)	Takes 14 – 40 days for this test alone

Colorectal BPTP variation summary

FIT completed (D7)	Taking up to 10 days (not all have FIT requested)
Triage (with FIT) (D7)	Taking up to 10 – 14 days
STT colon (D14)	Taking up to 16 days alone for Colonoscopy
Staging - CT following colon (D21)	Takes 12 – 16 days from the point of Colonoscopy
MRI / other staging (D21)	Takes 8 – 19 days for this test alone

Oesophageal BPTP variation summary

Triage(D3)	Taking between 1 – 9 days to complete
STT OGD (D7)	Taking 6-18 days to undertake from request
STT CT (D7)	Taking up to 18 days from point of request
PET (D21)	Taking 14-18 days to complete and report from requesting
Staging Lap (D27)	Takes 12 – 16 days for this test alone
EUS (D27)	Wait is around 6-32 days for EUS alone

Prostate BPTP variation summary

Triage(D3)	Taking between 1 – 5 days to complete
MP MRI (D5)	Taking 5-22 days to undertake from request
Prostate Biopsy (D9)	Taking 11-28 days from point of request
Other diagnostics (D14)	Taking 7-14 days to complete and report from requesting

It is clear that there is significant corrective action required across the GM system in relation to all diagnostic pathways. In addition to the existing actions a 'cancer week' Is suggested for diagnostics (and possibly surgery) – that would see maximum diagnostic capacity diverted from elective and routine work to create a system step change. GM Cells are asked to support the Cancer Alliance to fully scope this proposal, including the impact into other services (including elective long waits). It is accepted the urgent care pressure alone may prevent this progressing.

6. Surgical treatment volumes and compliance with the 4 week (28 day) clinical criteria

The P2 surgical treatment waiting list is current 72% higher than when it was first monitored, and 28% above the same period last year. This is impacting backlog

reduction, and the 31 and 62 day constitutional standards. Additionally, over 50% of patients booked are beyond the 4 week (28 day) clinical criteria.

Treatment volumes

Over the last 16 Weeks there has been a fall in the number of surgical treatments delivered in GM. The current weekly average is c250. Reported surgical treatments include (P3 estimated as approximately 13 patients per week.

In order to deliver the backlog reduction target, and improve the 62 day and 31day constitutional standards, the surgical waiting list needs to be reduced to pre-pandemic levels. This requires an immediate and sustained uplift in theatre activity. It has been shown that cases above 300 have been delivered previously, but not sustained.

Revised modelling indicates where the greatest needs for increased activity are by organisation and tumour site. A trajectory demonstrates that the required reduction could be achieved in 6 months if activity is delivered.

Waiting List Reduction Trajectory

	Baseline	Week																						
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
6 week average **P2 treatment** waiting list size	896	890	885	873	861	848	835	812	789	766	743	720	697	674	651	628	605	582	559	536	513	490	467	444
6 week average TOTAL Treatment numbers	248	270	275	300	300	300	300	310	310	310	310	310	310	310	310	310	310	310	310	310	310	310	310	310
Anticipated 6 week average P2 Treatment	235	257	262	287	287	287	287	297	297	297	297	297	297	297	297	297	297	297	297	297	297	297	297	297

Uplift in treatment numbers has been visualised by tumour site, with organisational estimates included, and the expected volume of theatre lists required, based on an assessment of the waiting list and complexity of current procedures.

	Average session length (rounded up to nearest 0.25)*	Surgical treatment numbers required per week on average	Number of Sessions Required	Organisation Specific Lists **
Brain	*1*	0	0	
Breast	*1*	48	48	
Colorectal	*1.5*	39	58.5	
Gynaecology	*1.25*	35	43.75	
H&N	*2*	25	50	Some MFT
Lung	*1.5*	9	13.5	MFT
Skin	*0.5*	7	3.5	
OG/Upper GI	*1.25*	7	8.75	NCA
Urology/Testicular	*1*	76	76	
HPB	*2.5*	9	22.5	MFT
Listed as other	*1*	10	10	The Chrisie
Paeds	*1*	0	0	
Sarcoma	*0.5*	0	0	
GM TOTAL		**310**	**335**	

	Current weekly throughput	Minimum throughput required	Number of additional patients per week	Specific Areas of Focus
Bolton	25	25	0	
MFT (inc NMGH)	63	91	28	Breast, Lung, HPB, H&N, Gynae
NCA	29	41	12	Gynae, Urology
Stockport	21	29	8	Urology
T&G	12	12	0	
The Christie	68	79	11	Colorectal
WWL	30	33	3	
GM Total	**248**	**310**	**62**	

A number of initiatives are underway to improve surgery treatment numbers.

- Maximising utilisation of mutual aid capacity in green sites – 8 mutual aid lists
- Redirecting surgical patients to alternative capacity - 15 patients weekly (MFT and NCA)
- GM Modelling refresh to help predict / manage future demand
- Recovery trajectories for the P2 cancer waiting lists being developed
- Biweekly elective prioritisation meeting established

- Focussed work with COOS and EMDs to reinvigorate surgical prioritisation groups
- Priority work on mutual aid arrangements for Breast and Bladder across GM (reducing variation in waiting times)
- Active work to increase capacity

If all available capacity at the Christie is used, this will still leave a shortfall of approx. 30-40 procedures per week, which will require trusts to increase throughput in their own sites. GM Gold are asked to support this action and for the trajectories to be implemented and monitored accordingly.

7. Existing Tumour Specific & Cross Cutting Service Improvement Work

Tumour Site	Improvement Initiative	Expected Impact Area (Existing pathway recovery aspects only)
Lung	Full work programme inc GIRFT, Audit, FDS	FDS, Backlog reduction, 62 day
Lung	Model of Care	Backlog reduction
Lung	Complex Treatment Clinic	Backlog reduction, 62 day, 31 DTT
Colorectal	FIT investment – labs, co-ordinators, primary care, patient engagement	FDS, Backlog reduction, 62 day, demand
Colorectal	Colon capsule endoscopy pilot	FDS
OG	Dietetic intervention clinic	Backlog reduction, 62 day, 31 DTT
OG	Cytosponge pilot	Backlog reduction, 62 day
Urology	Tula expansion	Backlog reduction, 62 days, 31DTT
Urology	Remote PSA testing	Release of capacity to support backlog reduction

Skin	Full dermatology work programme being established	Backlog reduction, 62 days, demand
Skin	Dermatascope roll out	FDS, demand
Breast	Mastalgia pathway & education programme	FDS, Backlog reduction, 62 day
Breast	Workforce development programme	Demand

Cross Cutting

Improvement initiative	Expected Impact Area (Existing pathway recovery aspects only)
Consolidation of oncology Outpatients	Backlog reduction, 62, 31
Single Queue Diagnostics (inc EUS & EBUS system C&D)	Backlog reduction, 62
Cancer workforce development	Sustainability
Best practice	Sustainability
AI Radiology Pilot	Sustainability
NHS Galleri	62 day

8. Recovery oversight

Cancer care is delivered as a system, with most pathways spanning multiple organisations. The approach to recovery must therefore be system focussed, looking at entire pathways and how they span organisational boundaries. Improvement must look beyond the aggregate standards to truly deliver improvement.

Pathway focus, milestone waits and incremental gains will become pivotal.

The GM Directors of Strategy in conjunction with the GM Cancer Alliance outlined an approach recovery which was supported by the Provider Federation Board. A pivotal element was the 'system first' focus, looking at the whole and not the sum of parts. The Cancer Alliance will lead this approach, and the development of an oversight approach was supported by the GM Cancer Board.

GM Cancer will establish a Cancer Recovery Panel to deliver this oversight on behalf of the GM system. The proposed Terms of Reference are included in APPENDIX 6. GM Cells are asked to approve this document.

In addition to monitoring key deliverables of the planning guidance, a heat map is being established to monitor pathway level improvement across GM, with the additional aim of reducing overall variation. An example of the heatmap in development is in APPENDIX 7.

9. Conclusion and Summary of Actions for Agreement

Recovery of cancer services in line with the planning guidance focus is essential. This includes:

- Reducing the backlog
- Increasing first definitive treatment levels
- Delivering the FDS standard
- Making improvements in the national CWT constitutional standards

Key additional actions for agreement

- Surgical trajectory implementation and monitoring
- Cancer week for diagnostics (and surgery) – to scope / risk assess
- Recovery Panel approach and ToR approval

Appendices

Appendix 1. RTT and conversion rates summary

RTT Booking Status May 22 & Conversion

Appendix 2. Best Practice Timed Pathway overview

BPTP Pathway Overview May 22 (GM

Appendix 3. P2 cancer surgical treatment modelling.

Cancer P2 Surgical Modelling June 2022

Appendix 4. Lung Improvement overview

GM Lung Cancer Performance Improve

Appendix 5. Single Queue Diagnostics Evaluation

GM SQD Evaluation Report March 2022 -

Appendix 6. Cancer Recovery Panel ToR

Proposed Cancer Recovery Panel ToR Ju

Appendix 7. Example heatmap

Example Heat Map .docx

Greater Manchester Cancer

Greater Manchester Cancer

2020–2021 Report

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Health and Social Care Partnership

Contents

gmcancer.org.uk

Foreword

Welcome to Greater Manchester Cancer's two year report for 2020 and 2021. In this document, we'll cover some of the key developments, challenges from across our cancer system in the last two years.

The last two years have been like no other, with healthcare providers and researchers around the world facing new, unprecedented challenges. Patients and families too have felt a significant impact, in what is already a difficult time for those affected by a cancer diagnosis. With our immediate focus having been on maintaining cancer services during the pandemic and with some of our teams redeployed to support this, we took the decision to delay our Annual Report - and so this report will cover both 2020 and 2021.

Whilst this time brought about huge change, our commitment and resolve across the cancer network in Greater Manchester has not changed – we are still determined to support more people than ever to reduce their risk of cancer, be diagnosed quicker and have the best experiences possible in terms of treatment, outcomes and overall experience.

It's true that COVID-19 has presented new and unexpected challenges as a system in terms of how we work, additional safety measures, system capacity and our changing knowledge about the virus to name a few. The adaptability of our researchers, clinicians, managers and patients has supported us to make significant progress both in getting services back up and running, ensuring their safety and making them better than they were pre-COVID. You can read more about some of the work undertaken by our teams in the COVID-19 section of this report.

Elsewhere, our work has continued across our pathways and I hope you'll see that significant transformation and progress has still been made across our system despite the challenges brought about by the pandemic.

We would like to thank all of our healthcare teams, researchers, user involvement representatives and patients for their dedication, commitment and cooperation to our cancer system through what has been a difficult few years for us all. Our teams haven't hesitated to put themselves at the cold face of the pandemic, working longer hours, in uncertain circumstances, accepting redeployment to unfamiliar areas and taking on additional volunteer roles, whilst seeing less of family and friends having their own personal fears.

The teamwork displayed across the Greater Manchester system is one of the things that we believe makes us truly unique and will allow us to come back even stronger after this very strange year.

We have a clear strategy for 2022 to continue our mission and we hope you'll join us as we work together for another 12 months.

Dave Shackley and Claire O'Rourke
Director and Managing Director
Greater Manchester Cancer Alliance

About Greater Manchester Cancer

Greater Manchester Cancer Alliance is one of 21 Cancer Alliances across NHS England, and the Cancer Programme of the Greater Manchester Health and Social Care Partnership.

We want more people than ever to reduce their risk of developing cancer, and for those who do go on to develop cancer, we want to improve survival outcomes and experiences throughout individual pathways, through earlier diagnosis, better treatment and supporting people to live well with and beyond cancer.

Our Cancer Alliance brings together clinical and managerial leaders from all hospital trusts and other health and social care organisations from across the entire region, alongside user involvement representatives and other partners, to transform the diagnosis, treatment and care for cancer patients in our area. Working in partnership enables care to be effectively planned across all parts of cancer pathways.

We also collaborate with the thriving research bodies in Greater Manchester, including The Manchester Cancer Research Centre, the Cancer Research UK Manchester Institute, The University of Manchester, Health Innovation Manchester and leading research trusts such as The Christie. By bringing together world-class researchers, clinicians and operational delivery, we have a unique opportunity to improve the lives of people affected by cancer in our region.

Each cancer pathway in Greater Manchester has a nominated Clinical Lead, who, working alongside their pathway boards, seeks to effect improvements in outcomes and experiences for people affected by cancer in Greater Manchester.

Greater Manchester Cancer also delivers a number of transformational and cross-cutting programmes of work, not specific to one cancer pathway, designed to improve overall care and experiences. You can read more about these throughout this report.

If you are interested in finding out more about our Alliance, or working with us in the future to improve the lives of people affected by cancer, you can find **contact details for the team** at the back of this report.

gmcancer.org.uk

For the latest on cancer research in Greater Manchester, take a look at the following publications from some of our partners:

The Manchester Cancer Research Centre Annual Report (2020)

Cancer Futures - Issue 2 (The University of Manchester)

On Cancer: Analysis and ideas on preventing, detecting, and treating cancer (Policy@Manchester)

Professor Rob Bristow also sat down with host Steve Bland for a special episode of our Greater Manchester Cancer Podcast, to look ahead at the next 12 months in cancer research.

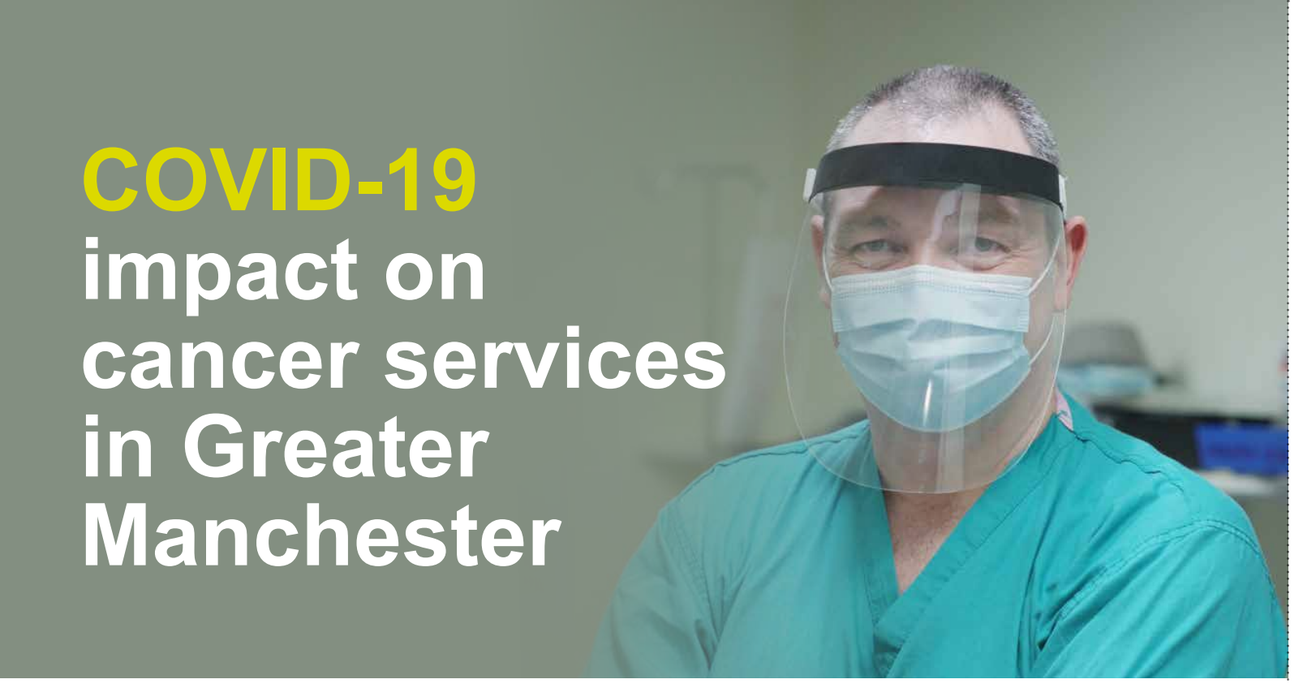
You can download the episode via Spotify or Apple Podcasts.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Health and Social Care Partnership

COVID-19 impact on cancer services in Greater Manchester



The COVID-19 pandemic has had a significant impact on the way we work.

Whilst there is evidence of this throughout our report, our first chapter will consider some key impacts, decisions and service changes which took place during the initial stages of the pandemic.

COVID-19 started appearing in the news early in 2020, and by March it had arrived in Greater Manchester. Wheels were already in motion within the NHS to prepare. Prime Minister Boris Johnson announced a nationwide lockdown on 23 March 2020.

At Greater Manchester Cancer, our priority was to ensure that our cancer patients faced as little disruption as possible, in the face of many challenges thrown at us by the pandemic.

Many staff were redeployed into front-line or supporting roles to support COVID-19 patients, including some staff moving to the Manchester Nightingale Hospital. Aerosol-generating procedures such as endoscopies, a key diagnostic tool in cancer, had to be paused whilst more was understood about the nature of how the virus spread and the safety implications of these procedures for both staff and patients. Additional infection-prevention and testing regimens for both staff and patients were also introduced whilst theatres were turned into overflow critical care spaces.

In addition to this, our workforce was impacted further by those contracting COVID-19 themselves or needing to isolate due to potential exposure.

This was also a very uncertain time for our patients, with their own concerns regarding safety, many requiring to shield and some experiencing changes to their cancer pathway. Those attending healthcare settings were also required to visit alone to reduce visitor numbers and in turn reduce the risk of infection.

Numbers of people contacting their GP with concerning symptoms, which could be indicative of cancer, also fell at the beginning of the pandemic, with many concerned about safety or not wanting to put the NHS under additional pressure. This was also the case across the rest of the country.

Despite the challenges, the cancer workforce in Greater Manchester worked extremely hard to ensure our patients continued to receive the best treatment possible, as quickly as possible.

Impact of the first wave of COVID-19 on cancer services in Greater Manchester

	Spring 2020	Winter 2020
GP REFERRALS (for suspected cancer)	30% of normal	>95%
Endoscopy services	<10%	>90%

Greater Manchester impact figures mirrored the position nationwide. Endoscopy services were severely reduced for safety reasons due to their aerosol-generating nature.

The next few pages contain just some examples of efforts made by our teams to look after our patients since the start of the pandemic and you will find many others woven into the rest of this report.

Virtual consultations, COVID-secure sites and new testing protocols

Reducing footfall at healthcare settings was one of the first methods used to reduce the risk of spreading virus. Telecommunications quickly improved, with patients often contacted, where appropriate, via telephone or video call in lieu of face to face appointments. This also reduced patient need to travel.

Patients continued to be seen face to face where appropriate and therefore COVID-19 secure pathways were designed to reduce cross-contamination. This meant that patients were treated in areas where no COVID-positive patients, or staff working in COVID-positive areas, were present.

Extensive COVID-19 testing protocols were also established for both staff and patients, in addition to a range of additional bio-security measures such as the use of Personal Protective Equipment (PPE).

Early emphasis on safe cancer treatments

In the initial wake of COVID-19, there was a lack of national guidance available regarding how and when cancer surgery should take place, and if any changes were required. Greater Manchester Cancer developed its own COVID-secure protocol for cancer surgery, considering both patient and staff safety. ‘This included:

- Self-isolation and COVID-19 testing for patients before attending healthcare sites for surgical procedures; and
- Synchronised movement of patients to COVID-19 secure areas of the hospital after their surgery.

These policies proved to be hugely advantageous, allowing surgical cancer treatments to continue.

A published audit was able to demonstrate the effectiveness of these measures in ensuring that cancer surgery in Greater Manchester was COVID-safe.

The Greater Manchester Surgical Cancer Hub

The Hub is a concept that has now been adopted around the country, with the Royal Marsden and GM leading the first models of these.

The Greater Manchester Cancer Team’s ambition was to bring together The Christie Hospital and Rochdale Infirmary (part of Northern Care Alliance (NCA)), both identified as ‘COVID-secure’ sites, to allocate cancer patients into available theatre capacity at these protected sites via specially developed clinical and operational groups. This would ensure urgent cancer treatment could continue whilst hospital capacity across other Greater Manchester sites was reducing due to COVID-19 occupancy.

This concept has continued since May 2020 and continues to offer surgery to patients where needed. The goal is for patients to be offered treatment locally within the appropriate time frame, but if this is not possible, the GM Surgical Cancer Hub should be utilised to carry out treatment.

The Hub has ensured that patients have received urgent cancer care in a timely manner during the COVID-19 pandemic. Since its inception, there have been no recorded cases of the virus being acquired as a result of patients presenting for treatment.

The collaboration between Rochdale Infirmary and The Christie has brought together a full complimentary cancer service treating breast, general surgery, gynaecology, plastics and urology cancers. The service helps to ease the pressure on other acute hospital sites across Greater Manchester and Cheshire. The Hub model is now being adopted for non-cancer cases across GM, and the Hub’s success means this approach is likely to continue indefinitely.

The Greater Manchester health system has demonstrated true collaboration throughout the pandemic with hospitals working together, sharing patients, sharing treatments and sharing diagnostic capacity. This ‘mutual aid’ has been paramount in the continuation of cancer care and we are very grateful for the cooperation of all parties involved.

Hospital Cross-Specialty Clinical Panels

With bed and theatre capacity reduced in many hospitals due to COVID-19 occupancy, hospital clinical panels were established, involving a cross-speciality group of clinicians who ensured that patients needing the most urgent surgical care were treated first, with cancer cases receiving the highest priority.

COVID-19 guidelines for all cancer pathways

Clinical Leads from each cancer pathway played a critical role in leading and developing new treatment and surgical guidelines where required in response to the pandemic, using the most up to date information available from NHS England, NICE and relevant Associations. More information about this work can be found later in this report, under 'Work of the Pathway Boards'.

Adjustments to treatment regimes

In order to keep patients safe and reduce their risk of contracting COVID-19, treatment regimens were reviewed and, where considered effective and safe for the patient, adjusted to allow a reduction in visits to hospital sites. This included things such as the use of oral treatments, chemotherapy and immunotherapy.

Case study

Treating patients with haematological cancers during COVID-19

'Patients with haematological cancers are severely immunosuppressed and at high risk of experiencing severe illness following a COVID-19 infection. Active chemo-immunotherapy, with or without radiotherapy, increases the susceptibility to infection and severe sequelae.

Greater Manchester was able to quickly put a strategy into place to continue to deliver services for patients.

The following was agreed between The Christie, MRI, Royal Oldham and Salford Royal Hospitals in April 2020:

- All 4 British Society of Haematology level 2b/3 units continued to provide chemotherapy, stem cell transplantation and cellular therapies for patients as per NICE guidance
- All staff on these units were retained and protected from redeployment to COVID-19 areas
- All in-patient wards administering high-intensity chemotherapy to patients were to be screened COVID-19 negative (green) areas
- Patients were to be screened for COVID-19 prior to admission and at regular intervals during their in-patient stay; and regularly prior to and during outpatient chemo-immunotherapy
- Weekly staff screening was introduced at all sites

This meant that all haematology services across Greater Manchester were maintained and able to treat patients in a safe environment.

The strategy ensured that we could effectively redirect patients if one site experienced capacity issues or, due to a surge of COVID -19 infections, was temporarily closed, ensuring non-COVID patients and those newly diagnosed were distributed to the remaining treating sites. The group planned and introduced effective screening of patients and staff on inpatient wards, clinic areas and day unit facilities to minimise outbreaks. This ensured that we were able to follow NICE guidance at all times, effectively manage our workload and continue to care for our patients.

Bespoke communications at the Northern Care Alliance (NCA)

In April 2020, the Macmillan Information and Support Service at the Northern Care Alliance developed an informative letter, developed in consultation with cancer professionals, as a way of reaching out to cancer patients within the North East Sector during the pandemic. The aim was to inform, reassure and encourage patients to contact relevant services for any support needs. We understood that this was an extremely anxious time for cancer patients and their families and that they were now facing additional worries such as anxiety coming to hospital for appointments, possible diagnostic and treatment delays alongside concerns around contracting the virus.

It was acknowledged by all that it was vital to reach out to these patients to offer information, support and advice. The initial scope of the project was to communicate key messages to patients such as advice for attending hospital and what changes to expect, inform them of possible changes to treatment and appointments and provide relevant contact details if they needed to access support.

Acknowledging that cancer can be a long term condition and that some patients live with the consequences of their diagnosis for many years, letters were sent out to patients who had been diagnosed at one of our hospitals (North Manchester General Hospital, The Royal Oldham Hospital, Fairfield General Hospital and Rochdale Infirmary) within the last 5 years.

The letters have encouraged patients to access support and also allowed us to identify common issues and areas of concern that cancer patients were facing during the pandemic and share these with teams to shape service improvements. The team was able to update letters to reflect common issues or concerns along with the latest guidance to ensure they remained effective.

Within days of the letters going out, the Macmillan Acute Oncology team and Macmillan Information and Support Team began receiving calls from patients. These calls have been varied and have ranged from clinical concerns and symptoms needing attention to questions about possible treatment delays as well as practical and emotional concerns.

The calls have highlighted several areas within pathways that require improvement and work began immediately to address these issues. The work has also identified a small number of more serious incidents allowing important investigations to take place and learning has been identified for future improvements. It has highlighted important issues which require further attention which in most cases has allowed issues to be resolved quickly for patients.

Teams continue to review the process and use the issues raised from these calls to inform improvement – for example, a steering group has been set up at a senior level to review surveillance and follow-up pathways including process mapping using a number of individual patients that were highlighted during the project.

Communications from the NCA team in the first 12 months

11,426
patients identified with letters sent

142
follow-up phone calls from patients

Letters continue to be sent to all newly diagnosed patients and in tumour-specific information packs

Informatics

Creating a Greater Manchester wide Patient Tracking List (PTL)

As part of the response to COVID-19, a major focus of the Greater Manchester Cancer Informatics Team in 2020/21 has been the establishment of a Greater Manchester wide Patient Tracking List (PTL). In partnership with Informatics colleagues from the Greater Manchester Health & Social Care Partnership, daily data flows from all providers of cancer care in Greater Manchester have been enabled allowing an up to date view of every patient awaiting cancer treatment across the region to be displayed within a single reporting system. This allows not only monitoring of patient waits, but also allows early calculation of performance against the national cancer targets such as the 'two week wait from referral to first outpatient appointment'.

Further reports, running from the same data flow, have included conversion rates, incidence reporting and reports relating to cancer presentations in emergency care settings.

Having the ability to gain insight into the Greater Manchester Cancer system, at a Greater Manchester level, has allowed clinicians and managers to really understand how the system is functioning during the pandemic and has improved the confidence in decision making.

Volunteer support at Wrightington, Wigan and Leigh

Cancer services at Wrightington, Wigan and Leigh Teaching Hospitals Foundation Trust (WWL) have always been well supported by our volunteers with some having been patients themselves. They have been an invaluable part of our daily work and have missed being able to come on to site to support us during the pandemic.

WWL was invited to bid for funding from NHS England as part of their Winter Volunteering Programme to enable us to use the volunteers in a way which kept them safe but still enabled them to play a vital role. The bid was successful and we have been able to support volunteers to 'work' from home. The funding has been assigned to provide volunteers with a telephone or laptop, enabling them to:

- Contact patients attending for clinics, reassuring them that it is safe to come in for their chemotherapy treatments and appointments, and asking the COVID-19 triage questions over the phone
- Respond to patient's queries and being a point of communication referring on to professionals when needed
- Provide 'comfort calls' to patients at home when discharged from secondary care
- Support patients who do not attend for their breast/cervical screening appointments

This work intends to improve communication between primary and secondary care and provide a more supportive environment for patients and their families during this time. It is envisaged that this work will carry on following COVID-19 and become a much valued service.

This approach fits with national priorities including the Cancer Adopt & Adapt recommendations to:

- Maximise the efficiency of the routes into the NHS for people with suspected cancer – particularly for those people who are less likely to come forward with symptoms (usually, and/or because of the pandemic)
- Remove barriers to access in seldom heard groups and strengthen awareness around the safety of accessing care
- Deliver stronger communication channels throughout pathways via support provided by navigators to ensure the patients understand the whole journey

COVID-19 Podcast

As part of the Greater Manchester Cancer podcast series, the team explore the impact of COVID-19 in episode one.

It explored some of the safety and treatment measures discussed above, considers how the Prehab4Cancer programme delivered its programme virtually and speaks to one of our patient representatives diagnosed during the pandemic about her experiences.

There are many other examples of projects and staff going above and beyond to support our patients throughout the pandemic, many more of which are woven into this report. Thank you to the cooperation of all of our staff and patients which has enabled us to continue to deliver cancer care across Greater Manchester.

Greater Manchester Cancer Podcast

You can find the podcast episode in all of the usual places | Spotify | Apple

Reducing the risk of cancer

There are many factors that can increase the risk of a cancer diagnosis. Before a person goes on to be diagnosed with cancer, it is important for us to take a step back and consider ways in which we can support the population to reduce their risk of developing cancer in the first place.

> *"Tackling smoking rates is a critical part of Greater Manchester's strategy to improve our population's long-term health. and wellbeing."*

Smoking

In the UK, smoking is the largest preventable cause of cancer and death[1, 2]. It is known to cause **at least 15 different types of cancer** and 15% of all cancer cases each year (more than 54,000 cases), **including 7 in 10 of all lung cancers**[3].

In Greater Manchester, 16% of the adult population smoke[4], equating to around 350,000 people – which is slightly higher than the UK average of 14.1%, although smoking prevalence among adults has fallen by almost a third since 2011.

With this in mind, tackling smoking rates is a critical part of Greater Manchester's strategy to improve our population's long-term health and wellbeing *and* is an important risk-reducing measure within our cancer strategy.

Making Smoking History

Greater Manchester's Making Smoking History strategy, which launched in 2017, aims to reduce smoking prevalence across the population and reduce the risk of cancer and other long-term health conditions. It aims to improve the health, wellbeing, and wealth of hundreds of thousands of residents and their families.

The 2019 ONS Annual Population Survey shows smoking prevalence in Greater Manchester has reduced by 2.4 percentage points since 2016, and by 4.3 percentage points among routine and manual workers. In addition, the latest Smoking Toolkit Study data shows **more than 40% of smokers in Greater Manchester are making quit attempts**.

There are now
52,000
fewer smokers than in 2016

The strategy works at both Greater Manchester and locality level and programmes of work include insight-led mass-media campaigns, reducing smoking in pregnancy, tackling illicit tobacco, a social movement within the VCSE sector, and system transformation.

At the outset of the pandemic in March 2020, resources were refocused to support the COVID-19 Emergency Committee for those who were homeless or sleeping rough in Greater Manchester. Nicotine management was provided to over 800 smokers in emergency housing through provision of e-cigarettes and support to quit.

There is a strong link between smoking and inequality, and data indicates that smoking rates are particularly high among the homeless and those with mental health conditions. They are nearly twice as high in those unemployed and seeking work compared to those in employment.

Smoking rates in some ethnic minority populations are diverse and are heavily driven by intersectionality with gender and socio-economic status. Smoking rates by ethnicity are highest among those identifying as of mixed or other ethnic origin but are also high among men identifying as of Pakistan or Bangladesh ethnic origin. Smoking rates among women other than of white or mixed ethnic origin are very low.

The pandemic has affected overall smoking behaviour positively. Analysis of YouGov's COVID-19 tracker seems to show that COVID-19 is increasing smokers' motivation to quit and stay quit. Although this is a window of opportunity, there is a clear social gradient from most to least affluent, with disadvantaged smokers half as likely to have tried to quit, half as likely to have reduced the amount they smoke and twice as likely to be smoking more indoors than they used to.

Work in this area continues.
For the latest news from the Making Smoking History team, visit makesmokinghistory.co.uk

Case study

> *"I never imagined I would be able to call myself an ex-smoker."*

Manchester nurse Marie Kirwan, 52, knows more than most the extreme harm caused by smoking, having witnessed the worst consequences first-hand. Yet, until just two years ago her addiction to tobacco meant she was 'sparking up' herself at the end of every shift.

Marie works as a research nurse at Wythenshawe Hospital, part of Manchester University NHS Foundation Trust, in the Thoracic Oncology Research Centre Hub (thoracic oncology deals with cancer located in organs, glands or structures of the chest).

Despite this, Marie was convinced that she would never be able to quit smoking. She'd been a smoker since the age of 16, having started while at sixth-form college.

A diagnosis of breast cancer changed all of that. The day Marie received the news she smoked her last cigarette.

Marie said: *"When my patients used to say to me 'I can't quit smoking' I genuinely understood their dilemma as I felt the same way.*

"There I was, sitting face-to-face every day with the heartbreak that can come from continuing to smoke, and yet after these conversations when I finished work, I would light a cigarette.

"I carried the shame and guilt that I was looking after, caring, nurturing, and guiding people away from something which I knew was wrong, while continuing to smoke myself. Now that I've successfully quit, those feelings have been replaced by pride for having overcome addiction and adversity. I never imagined I would be able to call myself an ex-smoker.

"I always thought that quitting would be the hardest thing I could ever do but it wasn't – the thought of giving up is much worse than actually doing it. If only I'd have done it 36 years earlier."

Dr Matt Evison, Greater Manchester Cancer's Lung Cancer clinical lead, said: *"Marie's story, although poignant, is unfortunately far from unique. Smoking is an addiction and the best way to quit is with support from specialist advisors, using medicines and nicotine replacement.*

"It is never too late to quit smoking. In fact, by quitting smoking ahead of chemotherapy or radiation therapy you can reduce the intensity of the side effects. Those who continue to smoke experience much worse symptoms than those who quit before starting treatment."

Dr Matt Evison, Greater Manchester Cancer's Lung Cancer clinical lead

1. Brown KF, Rumgay H, Dunlop C, et al. The fraction of cancer attributable to known risk factors in England, Wales, Scotland, Northern Ireland, and the UK overall in 2015. British Journal of Cancer 2018.
2. Global Health Data Exchange. Global Burden of Disease (GBD) Results Tool. Available from ghdx.healthdata.org/gbd-results-tool (link is external). Accessed October 2020.
3. Brown et al 2018, DOI: 10.1038/s41416-018-0029-6, www.nature.com/articles/s41416-018-0029-6
4. Office for National Statistics: Adult smoking habits in the UK Statistical bulletins

The CURE Programme

Whilst not all smokers may make a successful quit attempt in the community, the CURE Programme offers dedicated tobacco addiction support, including nicotine replacement therapy, other medications and specialist support to any active smoker admitted to secondary care for any health condition. This support continues throughout the duration of their admission and post discharge.

The programme began as a pilot in October 2018. Our 2019 ANNUAL REPORT reported the pilot's initial success and following this, the CURE service was rolled out to seven further sites in Greater Manchester. By autumn 2020, all seven sites which were allocated funding were live with the CURE pathway.

Our initial data demonstrates a significant improvement in the number of patients being offered and accepting tobacco addiction treatment when they are admitted to hospital across Greater Manchester.

Comparisons between the national average and Greater Manchester*

Nicotine Replacement Therapy offered to patients was **31%** from BTS audit compared to the

48%
offered from the GM CURE Teams

Only **35%** of the 125 institutions have consultant support, compared to

100%
of CURE sites

Across the 125 organisations involved in the BTS Audit only **2,528** patients were identified as smokers; whereas in Greater Manchester we have identified

15,364
(around 20% of adult admissions)

Only **44% (1105)** of patients were asked if they would like help to quit smoking, compared to

85%
(12,091)
across CURE sites

Only **777 (31%)** were then offered NRT compared to the Greater Manchester sites

7,550
(48%)

* Figures from the British Thoracic Society's National Smoking Cessation Audit 2019

Cost effectiveness

A Cost Benefit Analysis paper completed by the Greater Manchester Combined Authority (GMCA) sets out results from the CURE pilot which was based at Wythenshawe Hospital from 1st October 2018 to 31st March 2019. It then considers the costs of rolling the approach out across Greater Manchester, calculates the cost per quit including continued treatment in primary care, and considers wider impacts through a costs benefit analysis model.

Key results:

- The cost per smoking patient engaged by the programme in the CURE pilot was £104.23
- The cost per quit at 12 weeks post admission with the intention to treat was £475
- Gross financial return on investment ratio: £2.12 return per £1 invested
- Cashable financial return on investment ratio: £1.06 return per £1 invested
- Public value return on investment ratio: £30.49 return per £1 invested

The CURE cost per quit is significantly cheaper than the North West average (£532) and the England average (£490). Even assuming that none of the future healthcare savings assumed above would be cashable, the incremental cost-effectiveness ratioo (ICER) for this study would be £487. Programmes with ICERs less that £20,000 are deemed by the National Institute of Health and Care Excellence (NICE) to be value for money. Therefore this programme can be seen to be very good value.

Successful research publications

The CURE programme is producing unprecedented data and outcomes and as such, the team has published several papers on the programme. Dr. Matt Evison and CURE Research Assistant Hannah Clegg were successful in submitting a paper to be presented at the BTS Winter Meeting in February 2021. Hannah Clegg presented the paper 'Understanding the barriers and enablers to implementing a smoke free site across acute care trusts in Greater Manchester: results of a hospital staff survey'. This is a great achievement for both Hannah and Matt and the team were delighted when they were informed of the successful submission. Below can be seen a list of Publications available as outputs from the CURE Team and colleagues;

- The Cost Benefit Analysis Paper and Executive Summary
- Smoking & NHS Staff Survey Manuscript: Barriers and enablers to implementing smoke free NHS sites across GM
- Behavioural Insights Manuscript: Understanding the implementation of secondary care tobacco addiction treatment pathway (The CURE Project) in England: A Strategic Behavioral Analysis

Genomics

The Genetic Pathway Board continues to make progress in integrating genomic testing into cancer pathways. For some, this may provide indicators around future risk to self or to family members, which may lead to further counselling and where appropriate, preventative treatment interventions. More information on the work of the Genomics Pathway Board is available in the Earlier Diagnosis section of this report.

Healthy Populations

Our wider team at the Greater Manchester Health and Social Care Partnership continue to work on programmes to support the overall health and wellbeing of our general population including tackling obesity, promoting healthy eating and exercise and improving air quality.

You can find out more about their work by visiting their website.

Earlier and faster diagnosis

Early diagnosis not only improves patient long-term outcomes, but in many cases it can also radically improve the patient's experience, in terms of treatment options available, duration of treatment and/or the psychological impacts of the diagnosis.

The NHS Long Term Plan ambitions for cancer are that by 2028:

- 55,000 more people each year will survive their cancer for five years
- 75% of people with cancer will be diagnosed at an early stage (stage 1 or 2)

Current position

Greater Manchester Cancer has identified early diagnosis as a key priority. In Greater Manchester, 54.1% of cancers are diagnosed at an early stage, against an England position of 54.8% (according to latest data from March 2019).

The Alliance has built on the work undertaken before and during the COVID-19 pandemic by establishing an Early Diagnosis Steering Group, reporting to the Cancer Board. The Steering Group commenced in March 2021.

Earlier and faster diagnosis of cancer is dependent on:

1. **Public understanding and being aware of the early signs and symptoms of cancer**
2. **People taking up screening programmes or visiting a healthcare professional**
3. **Healthcare professionals awareness/ education / having the tools to hand to ensure a timely referral**

'Aim 1' of the national Cancer Recovery Plan issued by NHS England in December 2020 reiterated previous expectations in relation to restoring demand to at least pre-pandemic levels, giving examples of ways in which Cancer Alliances and systems are expected to support the identification, referral and diagnosis of patients at an early stage.

NHS England's key aims published in its Cancer Recovery Plan (2020)

Aim 1 Restore demand to at least pre- pandemic levels	Aim 2 Reduce number of people waiting longer than they should	Aim 3 Ensure sufficient capacity to manage future demand
• Run a major public awareness campaign • Ensure efficient routes into the NHS for people at risk of cancer, including through supporting restoration of screening programmes • Improve referral management practice in primary and secondary care	• Audit and focus on longer waiters • Implement urgent plans to increase/ manage demand for endoscopy and imaging capacity • Implement best practice and modified pathways to account for impact of COVID-19, and ensure patients are seen as quickly and as safely as possible	• Maximise use of available capacity (on both screening and symptomatic pathways) through system-wide working • Optimise use of available independent sector capacity • Enable restoration of other services • Take action to protect service recovery in preparation for winter

Public awareness

One important factor in the early diagnosis of cancer is public awareness, ensuring the public recognise and feel empowered to engage with healthcare professionals should they develop any potential symptoms that could require investigation.

World Cancer Day BBC News – Ovarian Cancer

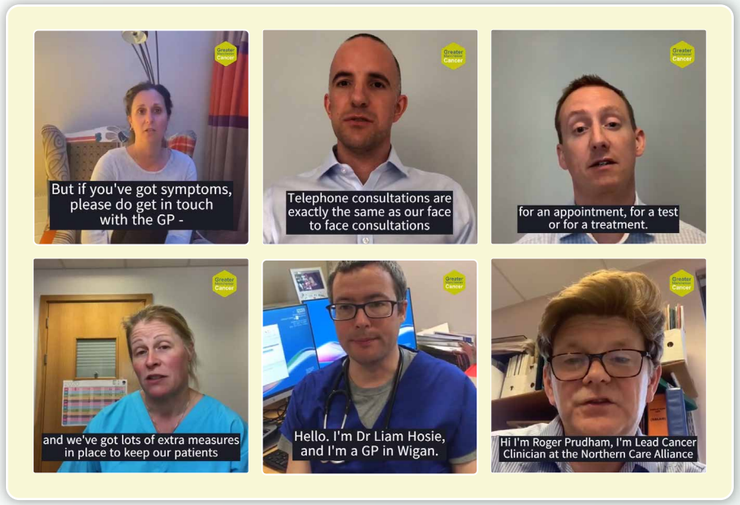
To mark World Cancer Day 2020, in February Greater Manchester Cancer's Director Professor Dave Shackley was invited to BBC North West Tonight to be interviewed live during an evening news bulletin on ovarian cancer, to highlight the work being done to support early diagnosis of these patients.

In addition to a film interview with Professor Jayson Gordon of The Christie NHS Foundation Trust, Professor Shackley was also able to raise awareness of the symptoms that the public should be aware of and where to turn should they have any concerns.

NHS #HelpUsHelpYou campaigns

During the pandemic, the NHS begun the '***Help Us, Help You***' campaign, reminding the public that key services were still open and available if required. A key part of this campaign was a focus on cancer, as clinicians saw a decrease in the number of patients accessing services and in turn, a reduction in suspected cancer referrals..

Social media campaigns were run throughout the year, involving a range of Greater Manchester GPs and secondary care teams, reassuring patients that they should come forward with concerning symptoms and that the NHS was prepared to treat them safely.

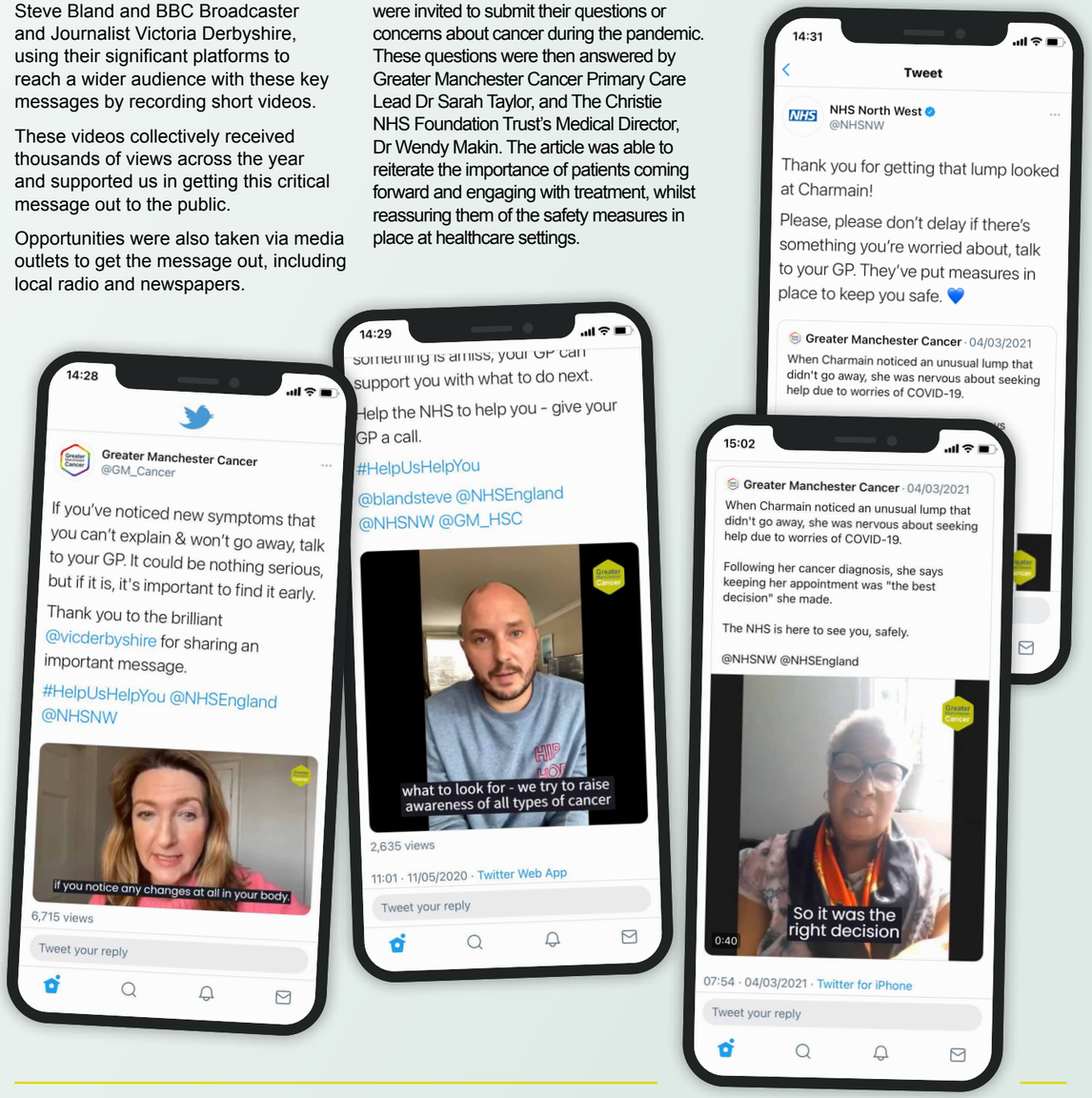


The Alliance also collaborated with ***You, Me and The Big C*** Broadcaster Steve Bland and BBC Broadcaster and Journalist Victoria Derbyshire, using their significant platforms to reach a wider audience with these key messages by recording short videos.

These videos collectively received thousands of views across the year and supported us in getting this critical message out to the public.

Opportunities were also taken via media outlets to get the message out, including local radio and newspapers.

On example of this was coverage in the Manchester Evening News, where readers were invited to submit their questions or concerns about cancer during the pandemic. These questions were then answered by Greater Manchester Cancer Primary Care Lead Dr Sarah Taylor, and The Christie NHS Foundation Trust's Medical Director, Dr Wendy Makin. The article was able to reiterate the importance of patients coming forward and engaging with treatment, whilst reassuring them of the safety measures in place at healthcare settings.



Do It For Yourself – Lung Cancer Public Awareness Campaign

From the beginning of December 2020 to the end of January 2021, and for a second phase in Summer 2021, Greater Manchester Cancer ran an outdoor public media campaign in collaboration with MSD, urging the public to contact their GP if they had symptoms that could be indicative of lung cancer. An identical campaign was also run across the Northern Cancer Alliance and both were funded by MSD.

Insight from focus groups conducted in September 2020 demonstrated a public lack of awareness of symptoms, underlying nervousness around COVID-19 and a desire to not put further pressure on NHS services that participants felt may delay them to seek help.

The public campaign focussed on outdoor advertising (bus stops, tram routes, service stations, independent pharmacy bags, spotify and radio), traditional media including newspaper and broadcast coverage (radio, TV) and social media. In the campaign's first phase alone, across Greater Manchester and Northern Cancer Alliance, the campaign generated 33 million opportunities to be seen by the public.

Upon review of suspected cancer referral data following the campaign, data suggests there may have been some early, modest improvements. Chest x-rays also increased modestly during this period. It is important to note however that the campaign ran in the midst of increasing COVID-19 restrictions – moving into Tier 3, then Christmas followed by Tier 4. This makes firm conclusions difficult to interpret from the data.

Following the initial campaign phase, the Alliance team continued to reinforce and develop public communications around lung cancer. It then also participated in a second phase in Summer 2021.

Separately, as part of the lessons learned from the campaign, the Alliance increased its focus on:

- The role of friends and family in influencing patients to seek help
- Challenging nihilistic views of lung cancer, through the use of case studies of patients living well 10 years + post-diagnosis
- Additional media advertising opportunities and paid social media, to target specific postcodes or patient demographics
- Targeting hard to reach groups and considering alternative languages. This includes a portfolio of lung cancer videos produced by GM Cancer in collaboration with AskDoc, reiterating key messages in 15 different languages

Screening

Screening programmes provide an opportunity to detect cancers at an early stage, in some cases before symptoms may arise. They are a critical part of the cancer pathway and support the NHS' ambition to increase the number of people diagnosed with cancers at stages 1 and 2, where treatment outcomes may be more favourable.

The three current NHS screening programmes for cancer are:

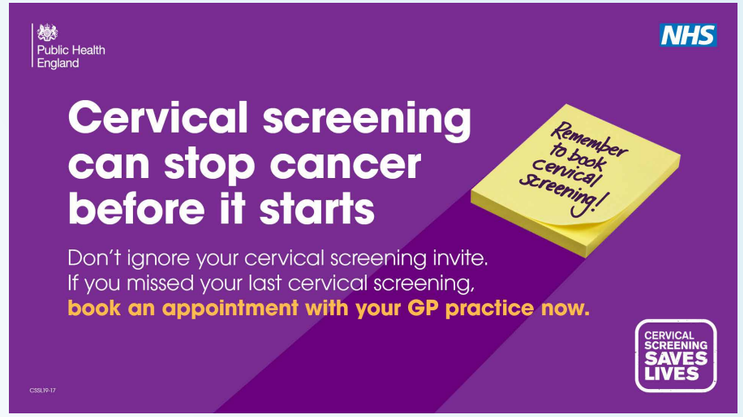
- The bowel cancer screening programme, also known as a FIT test (Faecal Immunochemical Test)
- Mammograms (breast cancer)
- Cervical screening

Greater Manchester also operates the Lung Health Check screening programme.

Improving participation and access to NHS Breast /Bowel Cancer Screening

The Greater Manchester Health and Social Care Partnership (GMHSCP) has developed and commissioned a new role within screening services with the ambition of improving uptake. The Cancer Screening Improvement Leads (CSILS) work in both Breast and Bowel Cancer Screening across the Greater Manchester conurbation. The need for these roles was identified through the work undertaken as part of the GM Cancer Vanguard workstream (2017/18).

A key priority for CSILS is to undertake a Health Equity Audit (HEA). The HEA's will inform programme action plans to support the Greater Manchester ambition to raise awareness of the importance of cancer screening, increase participation in breast and bowel cancer screening and reduce inequalities.



The CSILS have also implemented the following working in collaboration with key partners;

- The introduction of text messaging for improved patient communications in the Bowel Screening Programme via GP practices.
- Development of a GP practice toolkit which includes evidenced based ideas and top tips
- An additional support pathway for those living with LD to assist in the participation in the Bowel Screening Programme to ensure early diagnosis and treatment of Bowel Cancer and removal of polyps as a prevention strategy. (This is currently being piloted in Bury CCG, if successful will be rolled out across Greater Manchester) for the same approach is being taken for those in secure mental health settings, to ensure they receive the same offer and support.

Cervical Screening Improvements: Increased choice and access for women

Across Greater Manchester the Screening and Immunisation Team (SIT) have supported the development and implementation of a standard operating procedure (SOP) within the extended access services for the NHS Cervical Screening Programme.

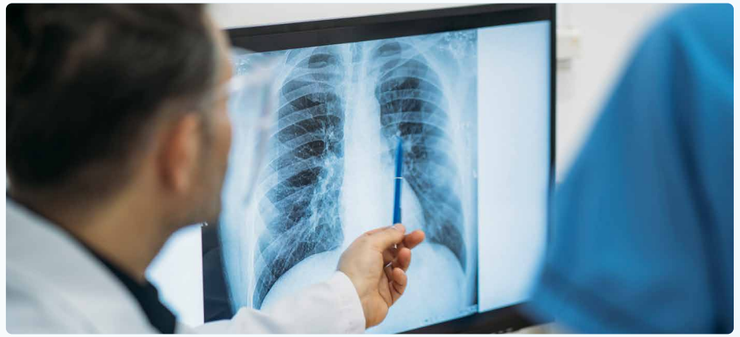
Extended access services are additional venues delivering the offer of a cervical screening test, outside a woman's registered GP Practice, across a 7 day period. In implementing the SOP there is assurance that quality, safety and standards are maintained within the programme. This provides a further substantial increase in choice and access to cervical screening service for women. Women can attend any practice within their network, which in turn provides resilience within primary care services.

ANSWER CANCER

Answer Cancer: Greater Manchester Cancer Screening Engagement Programme

The Greater Manchester Health and Social Care Partnership has commissioned a new voluntary, community and social enterprise (VCSE) sector partnership which aims to increase participation and uptake of Cervical, Breast and Bowel Cancer Screening across Greater Manchester. During 2020, a broad range of digital engagement activities were delivered throughout Greater Manchester. This facilitated positive conversations about cancer, challenged misperceptions, raised awareness, reduced stigma and encouraged people to act on their screening invites.

The community engagement work has continued to focus on the three NHS Cancer Screening Programmes, despite the challenges and impact of COVID -19. The team have promoted positive messages about screening and the COVID-19 safe procedures in place for people to access screening services safely during the pandemic. Furthermore, Answer Cancer has strengthened its online presence and has developed the GM digital Answer Cancer Champions initiative using social media.



Targeted Lung Health Checks

In our 2019 report we highlighted the launch of our Lung Health Checks programme across North Manchester and Salford.

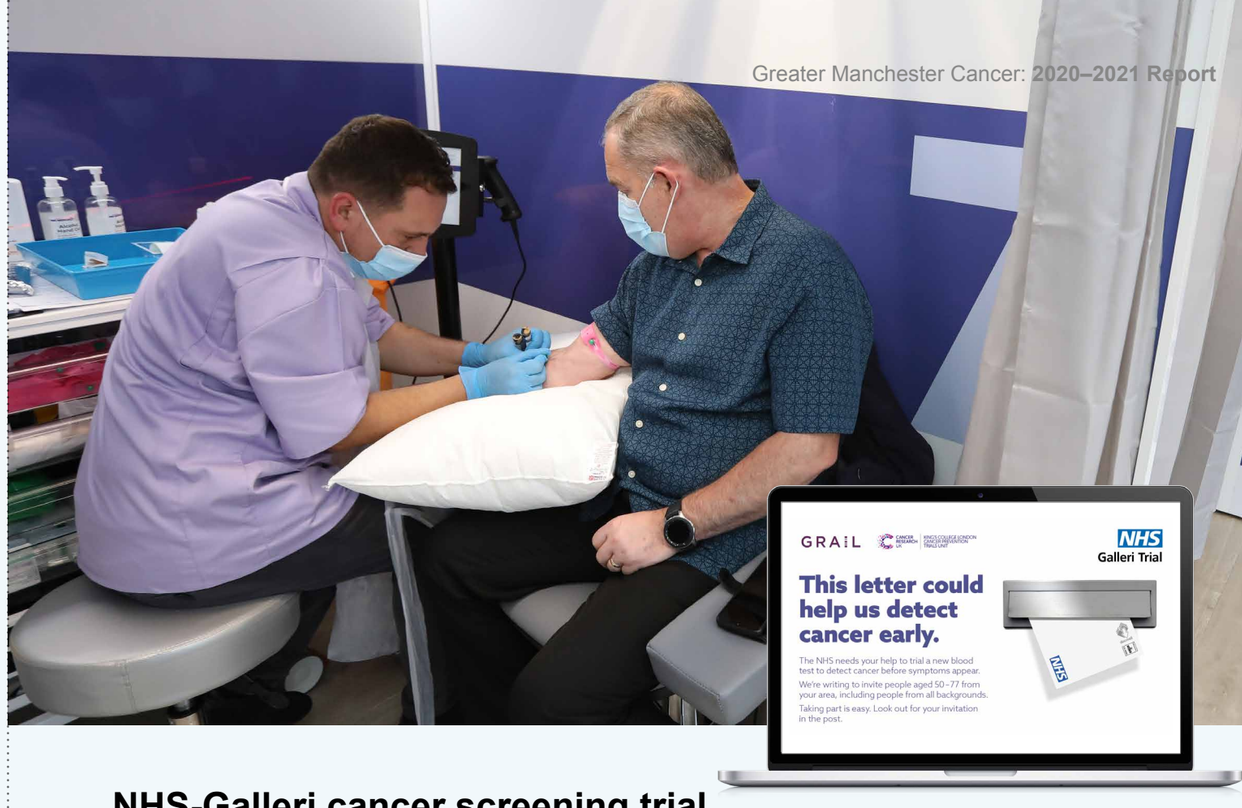
In Greater Manchester, lung cancer is the leading cause of premature death in the under-75s. This reflects higher smoking prevalence, higher levels of social deprivation and a greater contribution to the health inequality life expectancy gap, currently estimated at 10 years between the least and most deprived regions.

Increased awareness, smoking cessation, faster diagnosis and earlier stage diagnosis are regarded as the modifiable elements to changing the lung cancer landscape. The Greater Manchester Cancer Alliance has led several programmes to address tobacco addiction, accelerated lung cancer pathways and lung cancer screening, all driving the shape of the NHS Long Term Plan.

Following an early pilot of Targeted Lung Health Checks providing clear proof of concept, a National Targeted Lung Health Check (TLHC) programme has funded additional pilot sites in several cancer alliances. Since mid 2020-21, we have had three active TLHC projects in Greater Manchester: Manchester, Salford and Tameside & Glossop.

Results

- We have detected lung cancer in just under 4% of scans - a very high level due to our targeted approach with the vast majority of participants from deprived areas.
- By detecting 80% of lung cancers at an early stage of the disease (compared to a usual standard of 30%), the team has been able to significantly increase the proportion of patients receiving radical surgery. If rolled out across Greater Manchester alone, this could lead to thousands of lives being saved by 2030.
- The team also noted that one third of patients were at risk through undiagnosed heart disease. This in turn created the opportunity to commence these patients on suitable medication
- Half of current smokers attending their TLHC appointment accepted the offer to stop smoking, with a quit rate of 25%. If replicated nationwide, this could drastically reduce the smoking population, conveying huge health benefits for the nation.



NHS-Galleri cancer screening trial

In December, 2020 NHS England announced it was launching the NHS-Galleri trial, a screening trial conducted via blood test, aiming to diagnose up to 50 cancers at early stage. The trial is the latest initiative launched by the NHS to meet its Long Term Plan commitment of finding three-quarters of cancers at an early stage by 2028.

Greater Manchester has been selected as one of eight Cancer Alliance regions to participate in this trial and offer the test to invited members of the general public. The trial commenced in Greater Manchester in October 2021.

The trial is led by the Cancer Research UK and King's College London Cancer Prevention Trials Unit and healthcare provider GRAIL, who have developed the Galleri™ test.

The test is a simple blood test that research has shown is particularly effective at finding cancers that are difficult to identify early – such as head and neck, bowel, lung, pancreatic, and throat cancers. It works by finding chemical changes in fragments of genetic code – cell-free DNA (cfDNA) – that leak from tumours into the bloodstream.

Participants, who must be aged 50-77 and without a cancer diagnosis or treatment in the last three years, are invited by letter to have a small sample of blood taken at a mobile clinic based at one of the confirmed sites in Greater Manchester. They will be invited back after 12 months, and again at two years, to give further blood samples.

The potentially lifesaving Galleri™ test checks for the earliest signs of cancer in the blood and the NHS-Galleri trial, the first of its kind, aims to recruit 140,000 volunteers nationally, including thousands in Greater Manchester, to see how well the test works in the NHS. The trial team is keen to attract volunteers from different background and ethnicities to ensure results are relevant for as many different people as possible.

The first Greater Manchester area to participate was Oldham in October 2021. The mobile unit has since continued to move on to our other Greater Manchester locality areas and will complete its first round in early 2022, before commencing the second year of the trial and inviting participants back for their second visit.

Initial results of the study are expected by 2023 and, if successful, NHS England plans to extend the rollout to a further one million people in 2024 and 2025.

More information is available at nhs-galleri.org

Education

GatewayC is a Greater Manchester-born online education platform targeted at improving diagnosis of cancer within primary care.

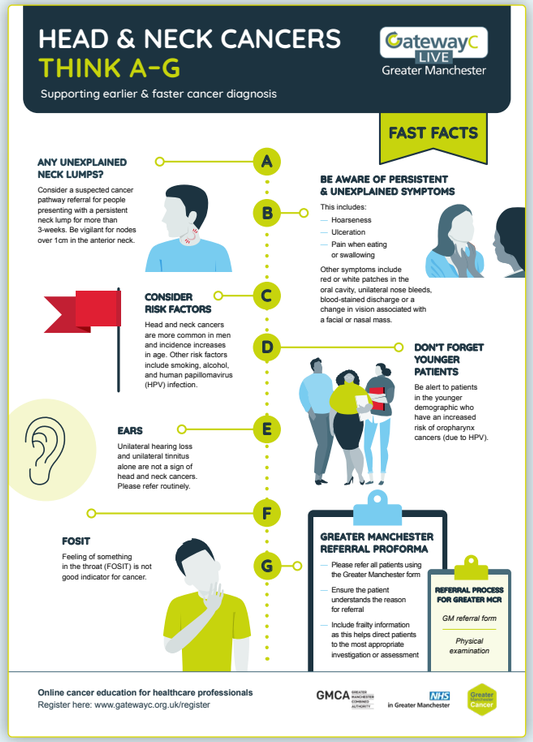
Since its inception in 2016 it has grown from a small local pilot to a nationwide programme, offering a range of educational courses on different cancer types, screening tools and treatments.

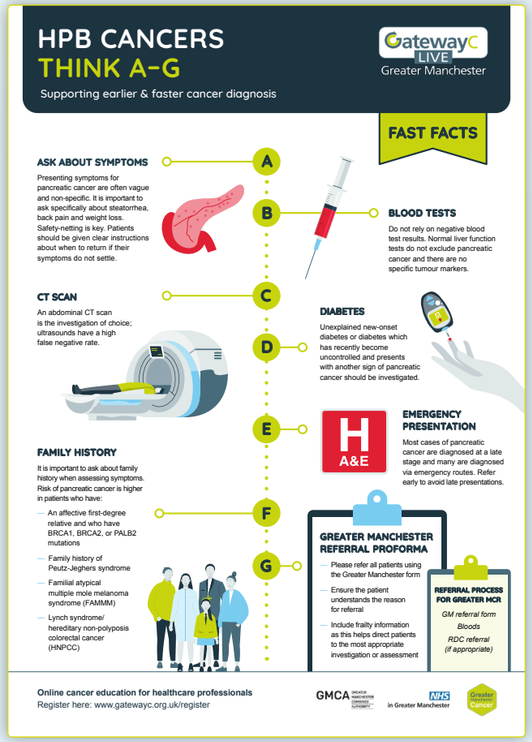
During the COVID-19 pandemic, the team expanded their educational offering to respond to clinical need, developing a range of “Cancer and COVID” resources including live webinars, featuring Greater Manchester clinicians.

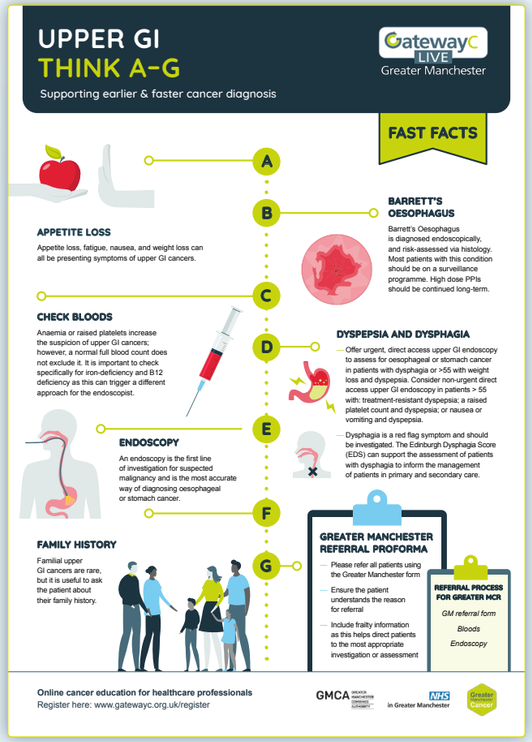
As the platform continues to grow nationwide, it also continues to extend its impact within Greater Manchester.

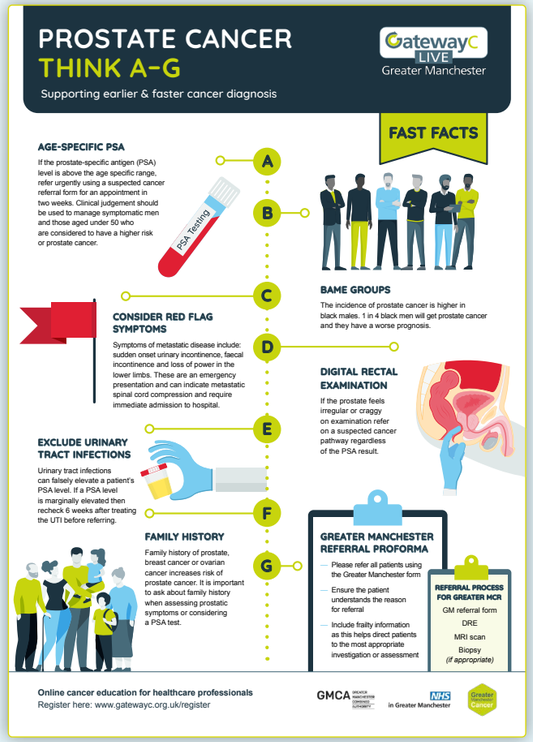
A new suite of webinars and educational tools have been jointly developed by GatewayC and the Early Diagnosis team under the umbrella of ‘GatewayC Live’. These include webinars on a range of cancer types featuring specialists from across the city region.

These are followed up with short video summaries and ‘fast facts’ infographics to embed key learning points. You can see some examples of these below.









Referrals

Throughout the pandemic, and in response to the national priority to ensure cancer referrals were returned to pre-COVID levels as well as retaining focus on the NHS Long Term Plan's priority to achieve 75% of cancer diagnoses at stage 1 or 2 by 2028, the Alliance has focused on a number of approaches to support the Greater Manchester system in working towards restoring demand to at least pre-COVID levels including:

- Focus on groups and geographies with low levels of presentation/referral for assessment
- Supporting Primary Care and Primary Care Networks for delivery of core contractual, QOF and DES requirements
- Primary care education: Working with Primary Care Cell, GP Board and GatewayC to ensure communication of key messages to primary care (e.g. Cancer or COVID-19 guidelines, use of FIT in primary care, GatewayC modules on COVID-19, lung cancer, lower GI).
- Community and VCSE engagement – ensuring public facing messages are communicated via the locality connections with community groups and VCSE organisations
- Patient and public facing communications – generic, population and pathway specific as required

> *"User Involvement representatives on the Head & Neck Pathway Board were particularly supportive of the proposals to introduce Advice and Guidance and gave their support for this work going forward. They look forward to the Pathway Board looking at how this useful process can also be available in other areas of primary care, such as dentists".*
>
> **Steve Sweeney**
> **User Representative,**
> **Head & Neck Pathway Board**

The work done to support the return to pre-COVID levels of referrals in Greater Manchester shows how GM Cancer has taken the opportunity support the system in identifying and addressing inequalities and variation, reviewing referral processes, being proactive in accelerating initiatives such as Advice & Guidance and PCN engagement and ensuring the system have access to the data required to identify where action needs to be taken.

To support the return to pre-COVID levels of referrals and to support delivery of 'Aim 1' of the national Cancer Recovery Plan, the Alliance has focused on a number of referral management projects, including the use of Advice and Guidance and a review and relaunch of all suspected cancer referral forms.

Advice and Guidance

Advice and Guidance is a tool within the national electronic referral system (e-RS) which enables a clinician to seek advice from another, providing digital communication between two clinicians: the "requesting" clinician and the provider of a service, the "responding" clinician. GM Cancer has identified and developed opportunities for the use of Advice & Guidance to support the Suspected Cancer Referral process as part of the programme of work to improve referral management practice in primary and secondary care.

The Alliance has worked with GM CCG Cancer Commissioning Leads, providers, Macmillan GPs, NHS Digital and the relevant Pathway Board Clinical Leads and membership to expand the use of e-RS functionality. There is an initial focus on pathways where there are reported challenges with the achievement of the suspected cancer referral standard, where there is an increased level of demand and where there is scope to provide GPs with additional information to inform their referral. Initial work has focused on Head & Neck, Skin, Gynaecological and Upper GI pathways. All work is being undertaken within the GM Advice & Guidance protocols approved via the Elective Reform Programme.

Review and relaunch of all suspected cancer referral forms

A review of all suspected cancer referral forms has been undertaken with support and clinical input from the GM pathway boards. All localities in Greater Manchester now have access to the same standardised referral forms that are in line with NICE Referral Guidelines NG12. These have been uploaded onto all GP systems in all 10 localities. This will ensure pathways and processes are in place to support further improvements in the quality of referrals made. The Alliance works with CCGs and Providers to ensure appropriate use of these forms and identify areas where there are issues with the use of them and provide any support required.

CCG Cancer Commissioning Managers, Directors of Commissioning, Pathway Board Clinical Leads, the GM Primary Care Cell and GM GP Board have been engaged in, informed of and supported the referral management improvements made by the Alliance. User Involvement representatives were particularly supportive of the Advice & Guidance initiative for Head & Neck pathways.

> *"The Primary Care Cell has been established as part of our GM response to the COVID-19 pandemic, bringing together clinical and managerial leaders from across our system. We identified Cancer as a one of our main priority areas at an early stage and have been joined by Alison Jones and Dr Sarah Taylor on a regular, scheduled basis to work through the key issues as they relate to Primary Care. We believe that this has helped considerably in allowing us to ensure that issues are raised and addressed in a timely manner and ultimately, has assisted our efforts to minimise the impact that the pandemic has had on those requiring referral, treatment or ongoing support."*
>
> **Rob Bellingham**
> **Manager Director,**
> **GM Joint Commissioning Team /**
> **GM Primary Care Cell Chair**

Diagnostics

Rapid Diagnostic Centres (RDCs)

In July 2019, NHS England published the RDC Vision 2019/20 Implementation Specification, which proposes that by implementing RDCs the NHS aims to provide:

- A single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer.
- A personalised, accurate and rapid diagnosis of patients' symptoms by integrating existing diagnostic provision and utilising networked clinical expertise and information locally.

The national vision is to take a phased approach to the implementation of RDCs over a five year period (2019-2024), embedding the 7 RDC principles:

- EARLY IDENTIFICATION
- TIMELY REFERRAL
- SYMPTOM ASSESSMENT
- COORDINATED TESTING
- TIMELY DIAGNOSIS
- ONWARD REFERRAL
- EXCELLENT CO-ORDINATION AND SUPPORT

RAPID DIAGNOSTIC CENTRES IN GREATER MANCHESTER

In line with these ambitions, along with those outlined in the NHS Long Term Plan, by 2024 Greater Manchester Cancer aims to have full geographical coverage for Non-Site Specific Symptom RDCs and every other suspected cancer pathway will have embedded RDC principles.

Benefits of an RDC approach

- Enables a reduction in the number of visits required by the patient to healthcare settings for an initial diagnosis
- Reduced non-attendance rates
- Improves patient and staff experience
- Includes an innovative use of workforce skill mix i.e. use of care navigators
- Using a digital platform – breaking bad news remotely so that patients are in the comfort of their own homes with family
- Improved performance for - 28 Days Faster Diagnosis Standard, 14 day suspected cancer referral (direct) and 62 days (indirect)

Position before COVID-19

The RDC model in Greater Manchester has evolved from the Multidisciplinary Diagnostic Centre (MDC) pilot, delivered 2017- 2019. In July 2019, the Greater Manchester Cancer Board agreed that the Northern Care Alliance Hospitals Group (NCA) and Manchester University NHS Foundation Trust (MFT) would lead the initial development of RDCs on behalf of the GM system, using a phased approach to build on the existing MDC services (ACE 2 pilot) at both organisations. In mid-March 2020, due to the COVID-19 pandemic, RDC development was initially paused both nationally and locally in Greater Manchester, whilst teams were redeployed to deal with the impact of the pandemic.

"I have found this to be an extremely professional, satisfactory way of working. Due to the rapid turnaround we are able to offer our patients from referral to first appointment, the patient experience has been overwhelmingly positive. I am able to meet the patient's needs in a holistic and patient-focused manner."

RDC team member

"The whole process was very speedy and efficient and the clinicians I met were very helpful and friendly. My key worker was so reassuring."

Patient

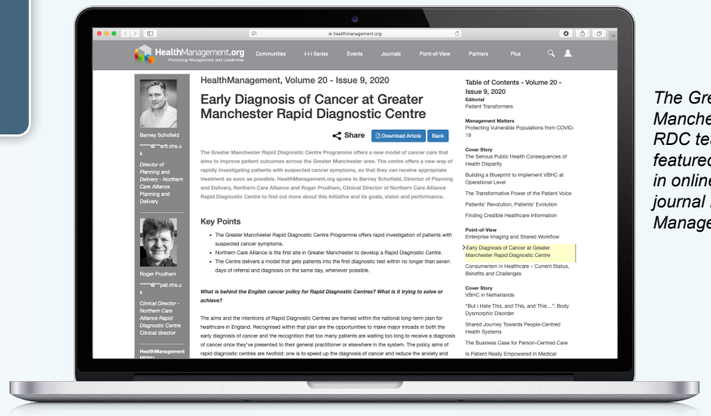
RDC approach as part of COVID- 19 recovery

In April 2020, NHS England, working with GM Cancer, issued guidance proposing that all cancer alliances accelerate RDC principles across suspected cancer pathways to aid COVID-19 recovery ensuring:

- Patients are seen more quickly, effectively triaged and safeguarded
- Diagnostic backlogs are reduced
- Resource and capacity are used efficiently and optimally
- There is ongoing flexibility in cancer services
- Virus transmission is minimised by reducing multiple appointments and movement between sites

In May 2020 our plans to continue to develop RDCs at Northern Care Alliance NHS Foundation Trust and Manchester University NHS Foundation Trust were re - accelerated resulting in the following:

- The Northern Care Alliance (NCA) model went live on the 15th June 2020 at two locations (Salford Royal and Rochdale Infirmary). The service currently runs over 4 days per week. It can be accessed by patients from Bury, Heywood Middleton and Rochdale, Salford, Oldham and North Manchester.
- This NCA site focuses on the non- site specific symptoms (NSS) pathway. Since June 2020, the clinic has developed a Malignancy of the Unknown Origin (MUO) pathway from the Emergency Department and receives referrals for patients with NSS redirected from the Gynaecology, Haematology, Upper Gastrointestinal and Lower Gastrointestinal cancer pathways.



The Greater Manchester RDC team featured in online journal Health Management

- The Manchester Foundation Trust (MFT) plan was adapted in light of the impact of COVID -19, focusing on the development of four site-specific pathways: Hepato-pancreatic biliary (HPB), Haematology, Gynaecology and Upper Gastrointestinal. The NSS pathway also went live in February 2021 and provides access to patients from both Manchester and Trafford.

The RDC team were also featured in an international health management online journal, (above) describing their approach, learnings from Greater Manchester and best practice in the RDC model.

Next steps

We plan to have full geographical coverage for Non Site Specific RDCs by the end of March 2022.

Single Queue Diagnostics

Another programme supporting our work to improve diagnostic performance and treatment times is Single Queue Diagnostics. Detailed analysis has shown that the majority of delays often occur at the front end of the patients' pathway and this project to form a 'Single Queue' will help address this issue.

The programme involves the design of a referral portal using Infoflex ®, a web based solution, which enables diagnostic appointments at different hospital trust sites to be visible on the same system, to offer patients a greater choice of dates and locations with available appointments.

The two diagnostic tests that were chosen for this pilot are Endobronchial Ultrasound (EBUS) and Endoscopic Ultrasound (EUS). These are one of the first diagnostic tests that assist clinicians at cancer MDT meetings in determining the best treatment for the patient, and forms an important part of the patient's journey to reduce their waiting time for treatment for cancer.

Feedback from a user involvement event informed us that the majority of patients would like to be offered an earlier appointment day, even if it meant travelling further than their nearest hospital site, to reduce the anxiety associated with waiting.

The aim of this pilot is to provide a proof of concept, following which there will be an evaluation with the aim to roll this model out further.

User Involvement Feedback

"I have been actively involved with the Single Queue Diagnostics Pathway Board and have been amazed at the work done behind the scenes by clinicians to shorten the time that a diagnosis is given to people suspected of having cancer.

The Single Queue Diagnostics offers prospective cancer patients the option to shorten the cancer diagnosis time by offering appointments at the first available hospital instead of having to wait for local hospital appointments to become available.

Most patients probably think that a consultant and his or her team simply works day to day diagnosing and treating patients under their care.

What they do not see is the many tireless hours of work done behind the scenes by groups like the Single Queue Diagnostics Team – work that is separate to the day to day tasks and very often in their own time, work that is designed to create faster diagnosis for the patient and subsequently faster access to treatment.

This can only be welcomed by myself as a previous cancer patient and part of the User Involvement team.

I am so proud to have been associated with this team."

John Tattum
User Involvement Representative

"As Diagnostic Lead we are here as a GM Cancer Network to support each Cancer Pathway to ensure timely and efficient access to diagnostic services. We work with our primary care and pathway leads to collate the diagnostic asks and priorities for each disease group, and with our diagnostic service providers to help improve the access and quality of our services.

The COVID-19 pandemic has emphasized the need for collaborative working across Greater Manchester. The diagnostics team have been working closely with the GM clinical support services board and GM imaging cell to establish Imaging and Pathology networks. Our focus has been to establish our baseline position and support recovery of diagnostic services activity and waiting times, equipment provision and workforce initiatives. We highlight variation in access to services and are supporting initiatives to reduce inequalities, including providing a single GM queue for bronchoscopy and endoscopy ultrasound services.

We are also partnered with the GM PACS programme in rolling out a single imaging system for GM and in using innovation funding to support establishment of digital pathology."

Dr Rhidian Bramley
Clinical Lead – Diagnostics Pathway

Pathways

Our Pathway Boards in Greater Manchester Cancer lead a number of workstreams aimed at improving the patient pathway, experience and outcomes.

Each board has a Clinical Lead at the helm and comprises of a wide range of stakeholders with expertise from across the pathway, who can challenge, advise and work together to progress each project and implement them effectively across the Greater Manchester healthcare system.

Representatives on each Pathway Board may include: Clinical Leads, Pathway Managers, Oncologists, Surgeons, Registrars, Doctors, General Practitioners, Clinical Nurse Specialists, Nursing Teams, User Involvement Reps, Dieticians and other AHPs, Advanced Practitioners, Researchers, Project Managers, Commissioners and other relevant representation as appropriate.

Pathway Board leadership during COVID-19

During the COVID-19 pandemic, Pathway Boards were instrumental in developing and providing clear guidelines for the management of each cancer pathway in response to any changes required, taking into account patient safety and other national directives. They provided clinical leadership to their teams across the Greater Manchester system and worked together to ensure the best possible care to patients at each stage of the pandemic.

Clinical services have adapted ways of working in order to continue to deliver safe, effective and high quality patient care.

The work of the Pathway Boards at this time included:

- Development of risk calculators to aid timely and safe decision making during triage of referrals
- Development of clear treatment and surgical guidelines, in line with best practice and national directives to ensure equity of access for treatment across the Greater Manchester population, whilst prioritising patient safety
- Providing clear clinical leadership during a challenging landscape of changes to PPE, testing, information about the virus, capacity and changing directives based on up to date information.

Case study

Use of FIT testing

At the beginning of the pandemic, endoscopy services were limited due to their aerosol-generating nature. This was the case across the country as the procedures were deemed high risk in terms of safety. The Colorectal Pathway Board were able to develop guidance on the use of Faecal Immunochemical Tests (FIT), to support the prioritisation of patients awaiting endoscopy. This was successfully carried out across all Trusts and is continuing to be followed. Guidance was also developed for the use of these tests by GPs within primary care, for all referrals, in collaboration with CCG leads.

Pathway Boards continue to acknowledge the impact of COVID-19 on their cancer pathways, using this opportunity to learn from new innovative ways of working and communication with patients, to improve the overall pathways and ensure excellent patient care.

User Involvement Feedback

"I have been impressed that throughout the pandemic the colorectal pathway board moved to a virtual meeting so all the meetings took place and the patient perspective continues to be valued and respected.

Service User Representatives continued, via the online meetings, to fully participate in the Pathway Board, as well as the Best Timed Pathway Steering Group. The Colorectal Small Community also operated on a virtual basis and over the course of the year provided input and comment on a range of patient communications, including Treatment Summaries."

Colorectal Pathway Board User Involvement Representative

Accelerated pathways

In our 2019 report we updated on work from three prioritised cancer pathways – lung, colorectal and prostate, aiming to streamline diagnostics in order to reduce the time between referral and treatment and provide all patients with a clear diagnosis within 28 days of referral by their GP. This should also provide a clearer pathway for patients with fewer visits to healthcare settings and enhanced communication.

The NHSE accelerated cancer pathways include rapid diagnostic principles and straight to test pathways. The GM Cancer projects commenced in April 2019 and concluded in March 2021. Each was a multi-stakeholder effort, including patients and carers affected by cancer and advising the project Diagnostic Sub Groups, Pathway Boards and further supporting and assisting with the development and creation of patient experience surveys and patient information.

Despite the critical impact of COVID-19, these pathways have now been achieved and implemented across Greater Manchester. The introduction of new Pathway Navigator teams across all three pathways has led to improved support for patients and their carers during their diagnostic and treatment journey.

Figures from the lung project show that:

- The number of occasions patients have needed to attend a hospital site for diagnostic testing has been reduced by up to 85%.
- Co-ordinated COVID-19 testing and arranging of appropriate patient transport has further reduced the number of missed appointments, subsequently improving the patients overall experience and reducing anxiety.
- Other clinical posts which were invested in by the project have also provided excellent results for patients, Trusts and the pathway.

Feedback from the prostate programme reports:

- The project supported the first diagnostic test, a prostate multiparametric magnetic resonance imaging (mpMRI) scan. This scan assists with risk stratification of potential prostate cancer and reduces the requirement for a biopsy in some prostate patients.
- In January 2020, only 10% of patients had biopsies performed using the LATP technique (Local Anaesthetic Transperineal prostate biopsy), which increased to 76% by December 2020 (instead of traditional transrectal ultrasound guided biopsy). This is significant as the LATP procedure reduces the risk of infection to patients, reduces the required length of hospital stay, only requires a local anaesthetic and is well tolerated by patients.
- The project also delivered bespoke educational events in particular to support the mpMRI and biopsy diagnostic steps.

Accelerated pathways are now also in development for Head and Neck and Gynaecological cancers.

Accelerated Pathways – User Feedback

The feedback from patients on these new accelerated pathways, collected via patient surveys, has been hugely positive – over 99% of patients surveyed rated the overall experience as good, very good or excellent.

"Without the support of the navigator, I would definitely not have been able to attend all my appointments, thank you."
GM Lung Patient

"As I live so far from the hospital I was amazed that my consultation, blood tests, radiotherapy planning scan and mould room appointments were arranged for the same day, I was very happy, this was a huge help and I think this helped me start my treatment sooner, thank you."
GM Lung Patient

"It is incredibly rewarding to have made a contribution to those patient journeys in the talks I have given and in speaking with health professionals so that they understand how to deliver the best care possible to provide the best outcomes."
Nic Clewes GMC Service User Representative, Lung Project

It's been great being part of the best timed prostate pathway steering group, using my experience as a patient to help make the pathway as easy as possible for future patients to follow."
Mike Thorpe, User Involvement Representative, Prostate Project

Other Pathway Board Highlights

Despite challenges posed by COVID-19, Pathway Boards have continued to roll out other transformational programmes of work and continued to deliver progress in other areas, including some of the following examples:

- **Education:** Pathway Boards have continued to develop high quality educational events, to ensure their clinical teams deliver the best care for patients.
- In **Acute Oncology**, the team has run Nursing Forum educational events on topics such as paraneoplastic syndrome, renal cell cancer, immunotherapy and prostate cancers.
- **Clinical Trials** – work to continue to provide access to clinical trials for patients carried on, with a range of academic and commercially-sponsored studies recruiting throughout the last two years, with set-up of new studies continuing and the number of patients recruited onto trials rising.
- **Mainstreaming Genomics** - The Genomics Pathway Board, led by Professor Fiona Blackhall, has worked in partnership with Pathway Leads to make progress in embedding genetic testing into cancer pathways.

  In **lung cancer** – Mayuri Basnet, Lena Joseph and Seamus Grundy from the lung pathway board are refining a reflex referral pathway for patients with metastatic non-small cell lung cancer to optimise turnaround times.

  In **breast cancer** – Clare Garnsey, lead of the breast cancer pathway board, has developed a reflex referral pathway for patients with risk of familial breast cancer.

"I was interested in getting involved due to good and bad experiences I had with attendance at A&E departments with acute oncology problems related to my chemotherapy both with my primary cancer 15 years ago and my secondaries 5 years ago.

I have found the experience of the MDT reform group very rewarding and feel the Service User contributions have been appreciated."

Alison Doyle
Service User Representative

Genomics Horizon Scanning

In **hepatobiliary cancer**, **upper GI**, **colorectal** and **endometrial** cancer – pathway board members have submitted applications for gene tests to the newly established national 'Genomic Test Evaluation Group' for inclusion in the 2021/22 genomics test directory.

Pathways have been preparing and finalising for routine Whole Genome Sequencing (WGS) of **haematological malignancies**, **paediatric cancer** and **sarcomas**. Panel gene testing for lung cancer has commenced ahead of the go live date.

Sarcoma: Metastatic Bone Disease

A sub group was formed to look at metastatic bone disease (MBD) combining the expertise of oncologists and orthopaedics and progress guidelines for MBD referrals.

Ultrasound Scan Guidance for Ovarian Cancer

In July 2020 the Gynaecological Cancers Pathway Board provided guidance for third party provider of ultrasound scans for ovarian cancer to primary care and commissioning colleagues. Similar guidance is being planned for ultrasound assessment of endometrium in 2021.This will help improve the early diagnosis process and help deliver the best timed pathway project.

Funding awarded for new genomics projects

The Genomics Pathway Board was awarded ~£150,000 for 2020/21 for projects entitled 'Paperless Genomics', 'Tissue is the Issue' and 'Embedding Genomics'. These projects will address digital integration of test results, the pathology requirements for expanded numbers of tests and quality improvement projects for current genomics tests.

Better treatment

With cancer treatment remaining our top priority throughout the COVID-19 pandemic, our teams across Greater Manchester put significant measures in place to ensure that this could continue.

This included a new Cancer Surgical Hub model, safety measures including patient and staff testing, use of PPE (Personal Protective Equipment) and a reduction of visits to healthcare sites, facilitated by telecommunication.

Our report covers some of these measures in more detail in our COVID-19 chapter, with additional information regarding treatment also features in the section ‘Pathways’.

Below are some examples of additional work programmes which have facilitated improved treatment for our patients during the past two years.

Radiotherapy and Proton Beam Therapy

In radiotherapy, The Christie NHS Foundation Trust’s radiotherapy team were able to safely alter the fractionation regime for some patient cohorts in breast, lung, upper GI and lymphoma. For breast patients in particular, data published as part of the FAST-Forward trial enabled the team to move to a five fractionation regimen that significantly reduced the number of times patients needed to come on to site. The Trust is now working with colleagues across the North West Radiotherapy Network and national groups to identify what changes made to regimens as part of COVID-19 response could be adopted in the longer term.

The Trust also invested in the equipment and software required to enable its consultants to plan radiotherapy remotely, reducing requirements for on-site working whilst maintaining excellence in care. Working together with Health Education England, the team made use of a number of third-year radiography students as radiography aids to improve COVID-safe flow within the department.

In protons, the closure of facilities in Germany to international patients meant that the team had to come together to increase general anaesthetic capacity by over a third to ensure that patients requiring this care were still able to receive their treatment. As schooling provision within proton beam therapy is a key part of the service provided, the team have moved teaching into a virtual learning environment, enabling patients to continue to take part in educational activities during their treatment.

Safe delivery of Systemic Anti-Cancer Therapy

There have also been a range of changes as part of the response to COVID-19 within our SACT services. Where clinically appropriate, oral treatments have been optimised to reduce the frequency of patient attendances on site.

Ward Three at The Christie has been redeveloped to provide additional treatment capacity, allowing for social distancing measures to be put in place in this area and in the Oak Road treatment area. The team also worked together to create additional socially-distanced capacity by increased The Christie at Home services and moving fully to six day working at the Oak Road site.

Greater Mancunians
Miss Susannah Penney

In December 2021, our Associate Medical Director Miss Susannah Penney was selected to feature as part of the “Greater Mancunians” project – a student-led landmark project photographing the people who have shaped Greater Manchester for the greater good.

This is an online project run by The Manchester College which has plans to materialise into a city-centre exhibition in 2022/23.

Susi has been recognised for her on-going contributions to patient care across the region and particularly her leadership during the pandemic to ensure cancer services were safe and continued to treat patients throughout.

Susi has been selected alongside other household names and flies the flag for the NHS and cancer services in Greater Manchester and we couldn’t be prouder of her.

You can see the project online here:
greatermancunians.blog

Prehab4Cancer

Our innovative prehabilitation and recovery programme was launched in April 2019, with funding available for 2,000 people diagnosed with cancer in Greater Manchester, over an initial two year period.

The region-wide service has had 1,700 referrals in the first 22 months of delivery, from clinical referring teams within the 8 GM NHS provider trusts referring patients from the 10 GM localities.

Patients accessing the service engage in bespoke exercise, nutrition and wellbeing interventions before, during and after their cancer treatment using local community-based leisure facilities close to their home, alongside digital support. We have partnered with 'GM Active', a collective of 12 leisure and community organisations, offering specialist training to their teams to help deliver a comprehensive prehab offering for patients in the 87 leisure facilities across the GM conurbation.

"I found Prehab extremely helpful. Having guidance on what level to exercise and having a specific program to follow helped me massively. My Wellbeing increased over the few weeks before surgery because the exercise really helped me focus. I had something to concentrate on rather than constantly thinking about my upcoming surgery.

It was great to have people helping you to be in the best shape you can be for the operation. Even though I only had a few weeks before my operation I found that my fitness levels and strength had improved."

Mrs M, Rochdale

Delivering the Prehab service during COVID-19

As the pandemic began, with the public staying at home and leisure centres closed, the Prehab4Cancer team developed a service model that could be delivered remotely. Hours before UK Prime Minister Boris Johnson announced the first national lockdown, the team were already busy filming exercise demonstrations to support patients when exercising for the Prehab4Cancer Youtube channel.

Prehab4Cancer Youtube channel

The remote delivery model includes the following elements:

- Initial assessments by telephone / video call
- Creation of a bespoke home exercise plan for each participant, sent out by email or post
- Supply of exercise equipment, including MyZone heart rate monitors and resistance bands
- Exercise demonstration videos via the website and YouTube channel
- Online group exercise classes (with almost 1,500 attendances recorded in 2020 alone)

By adapting and creating a remote delivery model, the team has been able to continue supporting 'throughout the COVID-19 pandemic and beyond.

Prehab4Cancer Website

Our new website launched in August 2020, providing an opportunity to reach a much wider audience of patients preparing for cancer treatment, their loved ones and professional colleagues across the globe.

The website includes advice on exercise, nutrition and wellbeing for patients, as well as a detailed description of the structure of the programme and information regarding how to refer patients into the programme for healthcare professionals.

Content has been developed to be accessible to everyone and includes video from patients who have participated in the programme, as well as colleagues from a wide range of disciplines who have been involved in the programme's design and delivery.

In its first six months alone, the website received over 30,000 visits.

Impact on patients

For the people affected by cancer who have engaged in the Prehab4Cancer service delivery, we have demonstrated the following benefits:

- Improved cardiovascular fitness prior to cancer treatment
- Improved muscle strength prior to cancer treatment
- Maintenance of nutritional status and ongoing management of nutritional needs through cancer treatment.
- Reduced development of mental health symptoms associated with cancer diagnosis and treatment, and an overall improved patient experience.

On average, people who have to access to Prehab4Cancer and Recovery service have an improved functional performance level at discharge (normally 4 months post-treatment) than they did at their baseline assessment.

For example, one Prehab4Cancer participant was fitter and more able to manage her daily activities after having half a lung removed in surgery than she was during her first assessment, shortly after receiving her cancer diagnosis.

Future Plans

Members of the project team are involved in a number of research initiatives relating to Prehab4Cancer. This includes EMBRaCE-GM (Enhanced Monitoring for Better Recovery and Cancer Experience in Greater Manchester) is a collaborative research project investigating how wearable fitness tracking devices can be used to improve clinical outcomes and quality of life for people affected by cancer in Greater Manchester. This project is a collaboration between clinicians, academics (primarily from The University of Manchester) and service users.

"Words cannot adequately express the positive impact Prehab4Cancer has had, not just on my recovery but also on my life. This team gets everyone through cancer treatments and prepares you physically and mentally for the return to normal life. They have responded proactively to the Covid19 pandemic and have continued to develop the service with their clients at the heart of everything. In my opinion, everything they do is exceptional.

The daily exercise classes meet the needs of all the clients, whatever level of fitness, at pre and post op recovery. They not only meet our physical recovery needs but also our mental wellbeing. The team and classes provide camaraderie and understanding which is not available anywhere else and in this time of isolation it has been my main point of contact with other human beings. More importantly they are full of fun and laughter. As the old adage says laughter is the best medicine."

Mrs B, Trafford

"Since moving from Scotland to be near to my sons I have not been able to give them a hug as I have had to shield but doing the online classes has made shielding easier and has made me feel like I have an extended family. The classes are so welcoming and the instructors are very good at what they do. Me and my husband look forward to the classes and we now plan our lives around them."

Mrs G, Tameside

The Princess Royal visits Prehab4Cancer

On 7 December 2021, Her Royal Highness The Princess Royal visited the Prehab4Cancer programme to meet some of the team involved and recognise the positive impact of the service on the lives of people affected by cancer.

As Patron of the Royal College of Occupational Therapists, Her Royal Highness alongside Greater Manchester Mayor Andy Burnham and representatives from the Greater Manchester Cancer Alliance, was introduced to a number of staff working on the specialist cancer programme, including exercise specialists, people affected by cancer enrolled on the service and its Allied Health Professional (AHP) Occupational Therapist Clinical Lead Zoe Merchant.

The Princess Royal was shown several demonstrations of typical prehabilitation assessments and interventions and heard first-hand the impact this programme is having on patients' physical and mental wellbeing in the lead up to and after cancer treatment. She also heard how the programme adapted to a virtual delivery model during the COVID-19 pandemic to ensure patients awaiting cancer treatment continued to receive this support.

The service offers evidence-based cancer prehabilitation and rehabilitation, designed to improve clinical outcomes with increased survival rates and improved morbidity. It incorporates exercise, nutrition and wellbeing interventions, in order to:

Professor Diane Cox, Chair of Council, Royal College of Occupational Therapists said: *"I am incredibly proud to be an occupational therapist. And never more so than during such challenging and rapidly evolving times, where adaptability has been vital. We're delighted that our Patron, HRH The Princess Royal has seen here today an exceptional example of how an occupational therapist-led service has adapted to continue to support patients during the pandemic, and is making such a positive difference to people."*

Tony Collier, a patient representative from Altrincham living with prostate cancer, who has supported the design of the service said: *"I am a massive advocate of the benefits of exercise – not only physically but also the positive impact it can have on your mental health, especially when dealing with the challenges brought about by a cancer diagnosis. "I'm thrilled to see how successful the Prehab team have been to date and hope to see this approach adopted across the country in future to support even more patients to live well during and after their treatment."*

Greater Manchester **Mayor Andy Burnham** said: *"Statistics now suggest that one in two of us will develop cancer in our lifetime, especially with many of us living longer, so it's crucial to ensure that we focus not only on catching cancer early, but also that people are supported to live well both with and beyond cancer. I'm proud to see the collaboration that's happened here in Greater Manchester and that this is now a model for best practice elsewhere to support our populations to continue to live well."*

Claire O'Rourke, Managing Director of Greater Manchester Cancer said: *"It is an honour to be visited by Her Royal Highness today to recognise the work of our Prehab4Cancer team. I'd like to thank all of our partners that have been involved in delivering this flagship initiative that has made such a difference to our patients. Greater Manchester Cancer is committed to developing innovative programmes of work that make use of the diverse range of knowledge and skills on offer from the range of healthcare professions within our system, so that we can continue to improve services for people affected by cancer across the region."*

Using genetics to personalise treatment

Roll out of genomic testing to make chemotherapy treatment safer for patients

The North West Genomics Laboratory Hub (NWGLH) was the first GLH to launch the DPYD gene test for patients receiving 5-flourouracil or capecitabine chemotherapy. The DPYD test detects patients who are at higher risk of side effects and means that chemotherapy can be made safer. Pharmacist Suzanne Frank and Clinical laboratory Head Philip Monaghan at The Christie provided essential leadership to ensure a smooth clinical roll out with rapid uptake across GM in the first weeks alone.

Launch of cancer agnostic NTRK fusion gene test

NTRK fusion is a rare genetic change that can occur in various types of cancer. NTRK positive cancers can be treated using precision medicines that target the NTRK fusion. These 'cancer agnostic' precision medicines are the first to be funded on the NHS. The North West Genomics Laboratory Hub was one of four (out of seven) labs ready to deliver NTRK testing when NICE approved these precision medicines in 2020.

Case study

Breast Cancer Familial Genetic Testing Pathway

From April 2021, NHS genomic testing in England was delivered through seven regional Genomic Laboratory Hubs (GLH), including our regional hub in Manchester, and according to mandated eligibility criteria set out in the national genomic test directory. This affects many cancer pathways and should facilitate equity of access to genomic testing nationally.

For individuals with breast cancer, the eligibility criteria have broadened, allowing increased access to genomic testing and, in turn, more personalised treatment options for more patients.

GM Cancer breast and genomics Pathway Boards have worked collaboratively with service user representatives to produce an introductory information pack for non-genetic specialists and their patients. This will allow breast clinicians and breast care nurses to assess eligibility for germline mutation testing, (BRCA1, BRCA2 and PALB2,) counsel eligible patients prior to testing, and request testing from the Genomic Laboratory Hub, without referral to our regional genomics tertiary centre at Manchester Foundation Trust. This will enable more timely diagnosis and treatment planning for patients, whilst reserving the regional genomics centre resources for patients who are found to have a germline mutation or other genetic abnormality.

The information pack includes an eligibility algorithm to support local breast MDTs, a counselling and consent document for breast care nurses and patients, a FAQ section about genetic testing and educational videos about how best to support patients through the new genomics pathway.

The GM Breast Cancer Genomics Testing Pathway was accepted for presentation at the Association of Breast Surgery Annual Conference 2021. We hope other cancer alliances will consider adopting our approach to support breast teams and their patients as we transition to this new, more inclusive, way of managing genetic testing.

Due to the cross-cutting nature of some of our projects, you can find additional information on other initiatives and progress in providing better treatment in the following sections of this report:

COVID-19 impact on cancer services

Early and better diagnosis

Brain tumour services

In 2021, Salford Royal and The Christie's brain tumour services received a national award for excellence in patient care.

Manchester's brain tumour centre has been recognised as a Tessa Jowell Centre of Excellence following rigorous expert-led assessments by the Tessa Jowell Brain Cancer Mission.

The national prestigious accolade was awarded to Salford Royal and The Christie and was measured on a range of criteria, including excellent clinical practice and training opportunities; emphasis on patient quality of life; providing clinical trials and offering a high standard of research opportunities.

Led by a committee of experts in the field and virtual site visits, the assessments were backed up by patient feedback about the care they received. It is one of 10 hospitals across the UK to receive the recognition.

There are more than 12,000 people diagnosed every year with a primary brain tumour in the UK, and approximately 600 new patients with primary brain tumours seeking treatment in Manchester.

Salford Royal Consultant and the Manchester brain tumour service lead Miss Tina Karabatsou, said:

"I would like to thank each member of the Neurooncology team for their commitment, passion and dedication and our management team who have been brilliant in supporting us as well as our patients and their families.

"We are honoured to receive this Centre of Excellence Designation on behalf of the amazing multi-disciplinary team dedicated to caring for brain tumour patients from across Greater Manchester and Cheshire. The Designation reflects the individual contributions of many people, working at Salford Royal, The Christie and in the community, as well as researchers at the University of Manchester, the Manchester Cancer Research Centre and the Geoffrey Jefferson Brain Research Centre."

Jess Mills, Co-Founder of the Tessa Jowell Brain Cancer Mission and Tessa's daughter, said:

"We are thrilled to have awarded Manchester's brain tumour service for its excellent ongoing work for patients and commitment to support other centres in reaching the same level of Excellence.

"Shockingly, the UK still has one of the worst cancer survival rates in Europe, but in time, the Tessa Jowell Centres will make the UK a global leader in the treatment and care of brain tumour patients. We have a long way to go until the cutting edge of science is delivered to every patient, but this is a huge and transformational first step."

Personalised on-going care for cancer

Personalised on-going care is a critical part of the cancer pathway.

Following diagnosis and treatment, patients may require additional support for many years, whether this be in the form of treatment, management of treatment side effects, psychological needs, other holistic needs or end of life care. We have implemented many changes to our projects over the last 2 years to support people in their follow-up care.

Personalised Stratified Follow-up

At the start of 2020, the Greater Manchester Cancer Transforming Aftercare Project was underway to put a personalised stratified follow-up pathway in place for all remaining breast cancer patients and adding to the teams that provided this for colorectal cancer patients.

A personalised stratified follow-up pathway is one where people are released from a pre-determined schedule of out-patient follow-up appointments. This is then replaced by direct access back into the treating team as and when support is needed. Evidence shows that this is a much more effective way of detecting cancer recurrences in patients.

However, this needs to be done in a safe way, to ensure that patients on this pathway are not lost to follow-up and have surveillance tests as scheduled when needed. This is done by tracking on a remote monitoring system – in Greater Manchester, the InfoFlex system has been selected for this purpose. The remote monitoring system is overseen by our Cancer Care Coordinators.

Living With and Beyond Cancer Project

In parallel, at the beginning of the year, the Living with and Beyond Cancer Project was driving the provision of the 'Recovery Package': this was the term for the targeted support package for patients at the end of their treatment to enable self-management on a personalised stratified follow-up pathway. Support was provided through holistic needs assessments, treatment summaries, health and wellbeing events and cancer care reviews.

Personalised Care for Cancer Project

During 2020, both the Stratified Follow-up and Living With and Beyond Cancer Project combined to for the 'Personalised Care For Cancer Project', to drive forward work to meet the key deliverable in the NHS Long Term Plan – to provide personalised care for cancer for all. Personalised Care is also highlighted as a key deliverable within the NHS Cancer Services Recovery Plan.

Key changes in the project now include:

- The expansion of the project's scope, to implement personalised stratified follow-up in all remaining colorectal cancer teams as well as all prostate cancer teams;
- In addition, following publication of a personalised stratified follow-up protocol by the British Gynaecological Cancer Society, a personalised stratified follow-up pathway is to be put in place across GM for endometrial cancer patients;
- A further 11 teams have been identified as test sites to develop a personalised stratified follow-up pathway and to test that model for further roll out across GM from April 2022;
- Following the national lead, the support provided to patients at the end of treatment to enable them to self manage their follow-up care has been adjusted so that it provides more personalised care to individual patients.

Some key achievements from the project include:

Project & Governance:

- Securing funding to expand the roll-out of personalised stratified follow-up;
- Identifying a host and remote monitoring system (InfoFlex), which has been built and implemented as a single system to enable appropriate sharing of data across Greater Manchester;
- A Personalised Care for Cancer Steering Group has been established with an expanded membership to include key stakeholders from across the health economy to ensure alignment with providing personalised care for all long term conditions;
- Working groups have been established to lead on the transition to a more personalised approach to delivering health and wellbeing information and support

Delivery:

- All breast cancer teams across GM have a Cancer Care Coordinator to support the team to provide personalised stratified follow-up, and between 46% – 56% of GM breast cancer patients are now on a personalised stratified follow-up pathway;
- We have been able to support the colorectal cancer team at Salford Royal NHS Foundation Trust to evaluate their long-standing personalised stratified follow-up pathway;
- We have been able to support an additional colorectal team at Pennine Acute NHS Trust to implement this pathway so that 50% of colorectal cancer patients are now offered personalised stratified follow-up;

Resources:

- Work has begun to redesign and revise the treatment summaries following a quality assurance process with the updated breast and colorectal treatment summaries now in use. The breast treatment summary includes an infographic designed by Greater Manchester service user Jo Taylor, highlighting signs and symptoms of secondary breast cancer. This work has been accepted as a poster for the Association of Breast Surgery Conference, 2021;
- A poster written by the Stockport NHS Foundation Trust Colorectal Cancer Team was accepted for the UKONS Annual Conference, 2020 entitled "The Cancer Care Coordinator, an economical version of a CNS or an essential addition to the CNS team in future proofing and ensuring the delivery of high-quality cancer care?"
- Our Personalised Care Event held in June 2020 welcomed over 100 attendees showcasing work to deliver personalised care for cancer.

Patient feedback:

"I found the appointment helpful in understanding what has been done so far and what will happen with my care in the future."

"I know the team are always there and I feel comfortable and confident to move forward."

"I am happy knowing I can always be seen if needed."

Secondary Breast Cancer Education Infographic

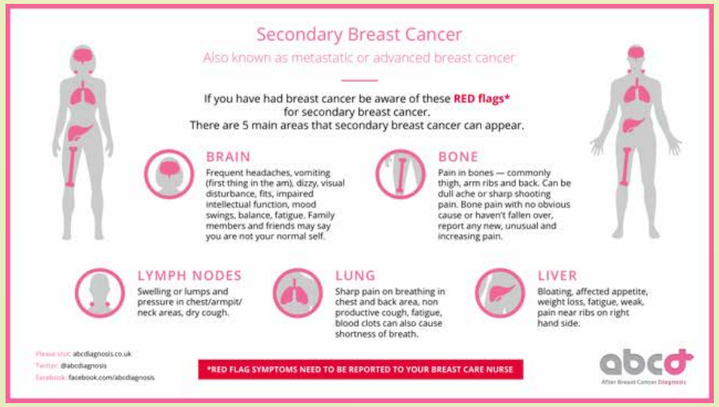
By the close of 2020, all breast services had started to deliver 'Personalised Stratified Follow Up' (PSFU). This is a NHS England-recommended, patient-led aftercare pathway that supports patients to manage their own aftercare. It also requires that patients and GPs are able to identify symptoms and signs of local and distant recurrence.

One of our service user representatives, **Jo Taylor**, designed an infographic that that provides clear, concise, accessible information about Secondary Breast Cancer signs and symptoms, and GM Cancer have adopted Jo's infographic. The infographic is now embedded within our regional standardised treatment summary which is given to every patient (and their GP) at the patient's 'End-of-Treatment' clinic appointment.

Clinical Perspective:
Clare Garnsey

"In a 2019 Breast Cancer Now survey, only 13% of people with secondary breast cancer (SBC) felt they were given enough information about the signs and symptoms of Secondary Breast Cancer.

Now that the infographic is embedded into the Greater Manchester Breast Treatment Summary, all individuals with a diagnosis of breast cancer will be provided with information about cancer recurrence. This is a huge step forward and a credit to Jo's hard work in raising awareness about the need for improved patient information about cancer recurrence.



Psychological support

In addition to on-going work to improve psychological support for people affected by cancer, services also adapted to consider the impact of the COVID-19 pandemic of people affected by cancer.

Education and training

A level 2 psychological support programme and group of trainers was established to provide training across Greater Manchester to health professionals. The two day programme curriculum incorporates screening, assessment (including risk assessment) and provision of a low intensity psychological intervention for management of distress linked to cancer diagnosis.

Prehab4Cancer

A psychological training and supervision plan was set up to support the personal trainers delivering the Prehab4Cancer programme, which continued throughout the COVID-19 pandemic. With sessions delivered remotely and many patients shielding, the contact and support from the Prehab team was recognised by many as a welcome support and lifeline during this difficult time.

Understanding views on psychological support

A questionnaire was co-produced to assess the satisfaction of psychological support during cancer care. This was successfully trialled at a Health & Wellbeing event for breast cancer patients and plans are to roll this out more widely as events recommence.

Establishment of psychological support project

During 2020, an additional project was established to develop the psychological support provision and services further in Greater Manchester. Its scope included:

- Understanding the impact of COVID-19 and psychological support in place through a co-produced questionnaire with service users
- Refreshing the existing directory of psychology services of existing psychology services and devising a communication strategy for accessing information quickly and to support clinical teams in referring patients for appropriate.
- Building on the work led by the education programme to provide standardised training and education for the whole cancer workforce. This will include ensuring that the needs of those supporting cancer patients following the pandemic are addressed.
- Ensuring psychosocial needs are considered during Multi-Disciplinary Team discussions prior to treatment.

Sexual health, fertility and early menopause

The Youth Support Coordinator team has facilitated a huge amount of digital support for young people across 2020, including both one to one and group support sessions. The team has also facilitated several pieces of work, led by young people that have been affected by cancer, producing information on sexual health and fertility. These resources can be shared with other young adults affected by cancer. The team also continue to work on information and resources related to early menopause.

User Involvement Representative Caitlin discussed the importance of emotional care for patients during GM Cancer's Virtual Cancer Week Event in 2021

Review of lymphoedema services

The Macmillan Greater Manchester Lymphoedema Programme was a two year programme that took place from January 2019 until December 2020. The partnership between Macmillan Cancer Support and Greater Manchester Cancer was set up to understand the need for people at risk and affected by lymphoedema across GM.

The approach would ensure Greater Manchester to have a cost effective, pro-active and sustainable delivery of lymphoedema that:

- Identifies people at risk, regardless of the cause of their lymphoedema
- Supports self- management
- Reduces co- morbidities caused by lymphoedema
- Provides timely assessment and treatment for chronic oedema/ lymphoedema

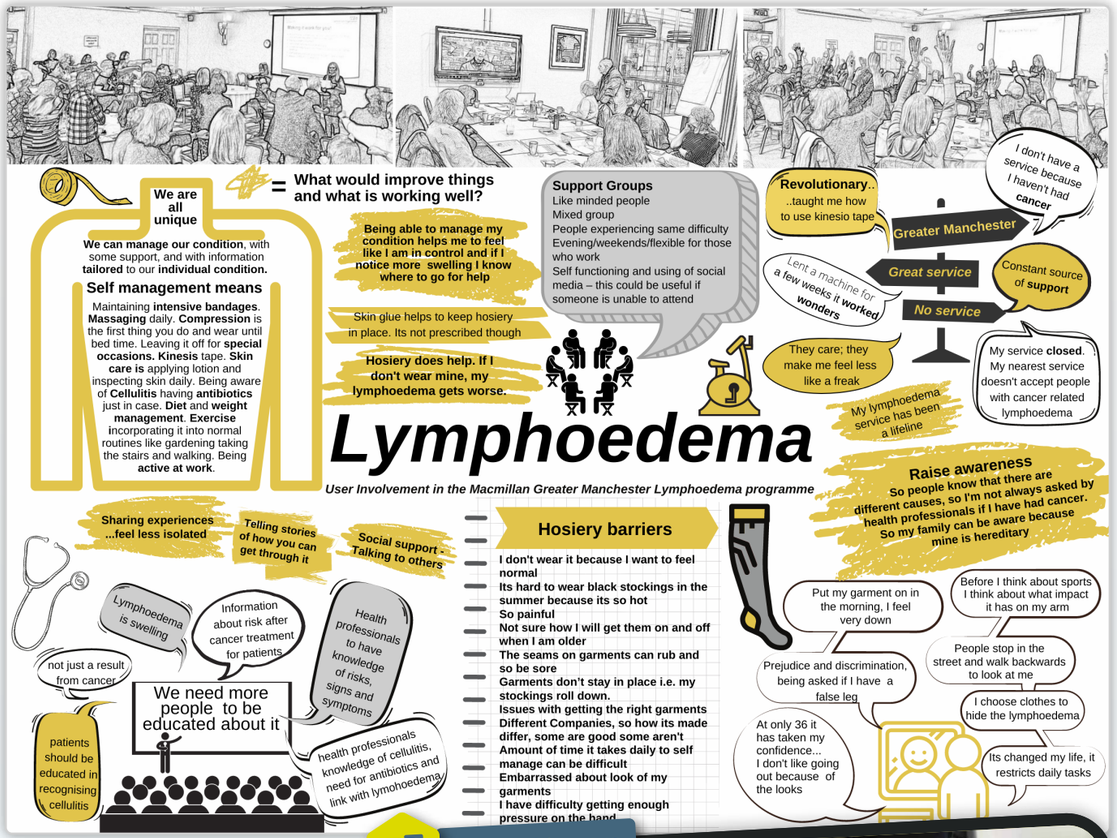
This extensive programme of work reported a number of outcomes including the development of a co-produced Model of Care for risk reduction, early identification and treatment and management of the condition. It also identified learning and development requirements and produced educational tools for healthcare professionals in Greater Manchester, delivered an educational event for service users and also contributed to a lymphoedema educational video as party of the national primary care education programme GatewayC's 'Managing the Physical Effects of Cancer Treatment' course.

A set of Greater Manchester standards was co-produced for the system to work together to achieve.

Learning & development	All relevant professionals provide risk reduction guidance: prevention & infection, weight management and exercise
	All patients suspected of lymphoedema are refereed to lymphoedema practitioner for diagnosis and appropriate treatment
	All people that are aware that could develop lymphoedema reduce their risk through self-care (weight management, risk and infection and exercise)
Provisions & ongoing management	Greater Manchester standards of lymphoedema treatment and care with agreed outcome measures
	A skill workforce for localities to provide appropriate treatment and support self-management for effective management of the condition
	All lymphoedema patients are empowered to self-mange or are supported through self-management
	Greater Manchester standards for reporting lymphoedema treatment and auditable patient notes
	Collaborative working between professionals for a person-centred approach it improve patients outcomes
	Great Manchester hosiery formulary for effective prescribing
	Streamline recording of incidence and prevalence within primary care data systems
Risk reduction	All relevant professionals know the sighs & symptoms, self-care guidance and how to refer to a lymphoedema practitioner
	All people that are aware they could develop lymphoedema are educated in lymphoedema & self-care to reduce their risk
	People affected by lymphoedema are educated and have access to information to self-care to improve their quality of life
	All relevant professionals have the national guidance competency levels of lymphoedema treatment and/ or supported self-management

Personalised on-going care for cancer

The project worked with a range of people affected by lymphoedema and produced this image summarising their thoughts.



The project established 16 on-going work priorities which are available to view on our website, along with a range of additional materials and resources connected to this project.

Resources include reports, the lymphoedema pathway, locality documents and also a range of educational video resources on various elements of skin care for different limbs to reduce lymphoedema risk.

The whole project involved stakeholders from across a range of localities and healthcare settings in addition to incorporating the views and experiences of service users affected by lymphoedema.

The programme also established an on-going transformation network for lymphoedema with representatives from across Greater Manchester services, which continues to meet every eight weeks.

Acute Oncology (AO)

The Macmillan Cancer Support and GM Cancer Acute Oncology two year programme January 2020 - January 2022 set itself high ambitions of:

1. Developing an AO service model in collaboration with all key stakeholders that will reduce the variation in access, outcomes and experiences - providing patients with the right care at the right time and in the right place.
2. Identifying sustainable funding for AO Services across Greater Manchester (GM), East Cheshire (EC) and Mid Cheshire (MC) through effective system wide-engagement including commissioners and providers to ensure that AO services are future proofed with sufficient flexibility.
3. Collaboration where appropriate with emergency care, ambulatory and or enhanced supportive care will be required in order to provide and demonstrate equality, resilience and meet the recommended national and GM clinical standards.

'Key achievements from the programme include:

- Formalised documents such as Consultant Roles and Responsibilities, Service Recommendations with modelling and COVID Management Planning
- Nursing Forum educational events – More information on this is available in the another section of this report, under 'Work of the Pathway Boards'.
- Ensuring the patient and carer voice remains represented throughout within working groups, through quarterly engagement meetings and via virtual correspondence
- Exploring and evaluating new ways of working through Associate Physician, Apprenticeships and Nursing Associates roles, in addition to supporting teams through newly designed modular Competency Frameworks and HR Passport opportunities. (This work collaborates with our partners Health Education England, UKONS, Macmillan and other appropriate stakeholder groups.
- Reforming Cancer of Unknown Primary (CUP) and Malignancy of Unknown Origin (MUO) services through initiating peer conversations around patient impact statement, standardised referral proformas and the centralisation of services.

Palliative and End of Life Care Advisory Group

A new, collaborative model of strategic working for palliative and end of life care has been established which is now referred to as the Palliative and End of Life Care Advisory Group.[1]

The aims of the group are to:

- Raise the profile and awareness of supportive & palliative care and promote an integrated oncology and palliative care model.
- To work with, and support, GM Cancer site-specific pathway boards to provide excellent palliative and end of life care
- To support patients' and their families to live as actively as possible, by providing high quality pain and symptom control, as well as practical and psychological support during diagnosis, treatment, palliative and end of life care, right through into bereavement.
- To ensure the views and experience of those who have been affected by palliative and end of life care are listened to and inform future planning and service developments.

1. This collaborative model of strategic working for palliative and end of life care was devised in conjunction with the Strategic Clinical Network (SCN), with the previous GM Cancer Supportive Care Management Group (SCMG) reconfigured, incorporated and co-chaired as one joint advisory group named 'The Greater Manchester & Eastern Cheshire SCN/Greater Manchester Cancer Partnership, Palliative & End of Life Care Advisory Group'.

Personalised on-going care for cancer

This new way of working has enabled both Greater Manchester Cancer and the Strategic Clinical Network palliative and end of life care leads to come together in unison throughout the COVID-19 pandemic, to support professionals working in palliative and end of life care across Greater Manchester and East Cheshire, meeting virtually each week to support, guide and share best practice.

The group is in the process of developing a suite of measures which will include:

- An overview of palliative & end of life care provision across GM (for professionals initially), which clearly outlines the roles of generic palliative care professionals in supporting this patient group and those of specialist palliative care, when the needs of the patient may be complex in nature
- The North West Model for Life Limiting Illness (previously known as The North West End of Life Model) in collaboration with the North West Networks which comprises 5 phases (from diagnosis of a life limiting illness, through to and beyond/into bereavement), with a Good Practice Guide which identifies key elements of practice within each phase to prompt the assessment process as relevant to each setting.
- Personalised treatment summaries for 'best supportive care' in collaboration with the personalised care team, to ensure what is important to the patient is clearly addressed and that this is reflected and communicated to primary care.

The group has also been integrated into discussions on multi-disciplinary team reform, to ensure the breadth of specialist palliative care is represented across cancer MDTs.

"Sincerest thanks for the organisation and facilitation of the SCN palliative and end of life calls. It really has been an invaluable source of information and updates that have really enabled us to not only get a wider understanding of national guidance, updates and advice, but, I personally feel, has also enabled us all as a GM team to come together during the most challenging of times".

Nicola Caffrey
Palliative and end of life and cancer services commissioning manager, NHS Bolton Clinical Commissioning Group

Palliative and End of Life Care for Teenagers and Young Adults (TYA)

During 2020, The TYA Pathway Board organised an online study day, led by Hanna Simpson - Teenage Cancer Trust Lead Nurse, for professionals that discussed critical topics pertinent to providing quality palliative and end of life care for teenagers and young adults with cancer. These included symptom management, early phase clinical trials in palliative care for TYAs, hospice care, bucket lists, family perspective and bereavement support.

The day had an excellent variety of speakers dealing with difficult and varied subjects and over 100 healthcare professionals attended the event, testament to the quality of speakers involved and Hanna's organisation and support.

Workforce and education

In 2020, GM Cancer established a workforce steering group to bring together all key stakeholders across the region, leveraging collective expertise, capacity and resources to discuss initiatives, share best practice and accelerate the delivery of key cancer workforce priorities.

This culminated in a regional Workforce strategy aligned to the National People Plan, Cancer Workforce Plan and Long Term Plan.

The 5 year strategy will support the growth and development of the cancer workforce so that they can respond to the needs of people affected by cancer, adapt to new, improved ways of working, continue to modernise the way they work and embrace technology in order to deliver the best quality healthcare. The strategy has been one of the first produced by a cancer alliance and so has received a lot of interest from other alliances.

The activity within the strategy aligns with the following pillars found in the NHS People Plan:

- **New ways of working**
- **Belonging in the health and care system**
- **Growing and training the workforce**

Here are a few highlights from 2020/2021

New ways of working

Piloting new roles

1) Physician Associate pilot

Greater Manchester Cancer was the first alliance to pilot the role of the Physician Associate (PA) within cancer services. During the COVID-19 pandemic, PAs were recruited to support numerous pathways including urology, lung, acute oncology and within 6 months were independently running their own clinics and in urology specifically performing diagnostic tests, as a result helping to reduce the pressure on the CNS and consultant workforce. The pilot has since been evaluated and shared nationally due to its success. A key part of the strategy is to further increase the number of PAs including piloting the role in endoscopy and other cancer pathways to increase the skill mix of our cancer workforce.

2) Cancer Support Workers pilot

In response to the Long-Term Plan ambition to deliver more person-centred care to all cancer patients, Greater Manchester Cancer successfully piloted the role of the Cancer Support Worker (Cancer Care Coordinator) in 2020/21. 3 trusts across GM were involved in the pilot and the role proved to be invaluable to both the CNS workforce and patients and positively impacted on cancer pathways.

This project has delivered benefits to patients through the enhanced offer of personalised care and alleviated workload from the CNS' and wider team to enable them to dedicate more time to complex patient cases. Over 90% of CNS' advised they would not be able to facilitate a Holistic Needs Assessment (HNA) clinic without the support of the CCC, and 100% of CNS' advised that patients benefit from having a CCC as part of the team.

This role was essential throughout the response to COVID-19 by displaying adaptability to delivering the most appropriate patient care. The CCCs acted as point of contact and was readily accessible for patients and their family/support network, providing vital support calls for patients through a time of heightened anxiety and uncertainty. As a result of this pilot all trusts across GM have CCCs embedded across cancer pathways to support the delivery of personalised care interventions to cancer patients.

Belonging in the health and care system

One of the key ambitions in the NHS People Plan is 'Belonging to the NHS' focusing on inclusion and reducing inequalities within the workforce. It cites strong evidence for promoting an NHS workforce representative of the community that it serves, as findings suggest patient care and the overall patient experience is more personalised.

Supporting our LGBT communities

In 2021, Greater Manchester Cancer Alliance joined forces with the LGBT Foundation to offer a free training series for those working in cancer services across the region to increase their understanding and awareness of the needs of our LGBT population.

A number of courses were selected from LGBT Foundation's Training Academy that were felt would benefit our teams in supporting LGBT staff and patients. Sessions were free for members of the Greater Manchester Cancer Network, including Pathway Boards, User Involvement Representatives and the GM Cancer Team. This was also then extended out to the wider GM NHS and cancer research networks.

These included:

LGBT 101: Terminology, legislation and inequalities
An introduction to all things LGBT

Trans and Non Binary Inclusion
Get to grips with trans status, gender identities and inclusive language including using pronouns and titles.

Asking LGBT Inclusive Questions and Having Challenging Conversations
Get to grips with asking someone's pronouns, managing mistakes and challenging discrimination.

LGBT Health Inequalities, Access and Signposting
Understand the health inequalities and disparity of outcomes experienced by LGBT people and consider how services can become more inclusive.

Upon completion of these modules, attendees were offered NHS rainbow lanyards and badges to wear where appropriate in the workplace to demonstrate their allyship to LGBT communities.

Feedback

Sessions were well attended, with attendees from a wide range of roles including user involvement representatives, clinical psychologists, project managers, clinical nurse specialists, Prehab4Cancer exercise specialists, research managers, research practitioners and communications teams.

From this training alone, teams are already noting how they can make their clinical practise or services more inclusive.

"Following the LGBT 101: Terminology, legislation and inequalities session, I noticed that our referral form needed to be adapted. I asked the LGBT trainer how you could ask for gender on a digital form to be more inclusive. Following his response, I have requested a change on by our database provider to reflect the learnings – We are changing from Male, Female, Trans to Male (inc. trans man), Female (Inc trans female), non-binary, other."
Kirsty Rowlinson-Groves
Prehab4Cancer Programme Manager

"I wanted to understand some of the issues that this community have. I know that there is discrimination and abuse towards this community but I wanted to understand more about why this happens and how we can become more inclusive.
I've really enjoyed the opportunity to learn something new and be able to debate it with people I've never met before.
It's been a really great thing to do, it's opened my eyes to some of the issues this community faces and has given me lots to think about and consider."
Geoff Burn
User Involvement Representative

Growing and training the workforce

Our Pathway Boards provided a variety of educational events for healthcare professionals throughout 2020, some of which are highlighted in the 'Work of the Pathway Boards' section of this report.

The team also begun planning for **World Cancer Day (February 2021)** and **Virtual Cancer Week (May 2021)** – two virtual events offering a variety of cancer-based educational sessions for healthcare professionals, researchers and people affected by cancer across Greater Manchester. With our network unable to join together in person as per our conferences held in previous years, these virtual events were designed to provide the same educational seminars and motivation as in previous years.

World Cancer Day 2021

On Thursday 4 Feb 2021, Greater Manchester Cancer held a virtual event to mark World Cancer Day. It aimed to unite the system and provide clear messages on the current situation during the pandemic whilst also motivating and inspiring both our workforce and people affected by cancer.

The agenda combined both clinical delivery and research and also focussed on challenges at both local and national level. The agenda was co-designed with service user representatives, with the patient voice represented throughout the day. Peter Johnson, National Clinical Lead for Cancer and Andy Burnham, Mayor of Greater Manchester also presented as part of the event.

Key challenges including COVID, performance, early diagnosis, health inequalities and engaging communities were considered throughout the morning, closing with a panel session and lively Q&A from the audience. Tony Walsh also launched his poem for the first time with more information overleaf.

The event attracted 630 registered users with sessions also available to watch on demand after the event.

Feedback was incredibly positive with social media engagement also high during the day.

"I thought it was absolutely brilliant - really made me proud to work for GM Cancer services and boosted my mood. Andy Burnham and Richard McCann were the highlights for me but everything was stupendous. Thank you."
Attendee feedback

"Thank you very much for the invitation: that was really quite an event, and I have kept an eye on some of the contributions later in the day. I think you can be very proud of what you put together, which reflects so well on all that is going on in Manchester."
Peter Johnson, National Clinical Lead for Cancer

"Innit, Love?"

Renowned Manchester poet **Tony Walsh** was commissioned by Greater Manchester Cancer to produce a poem for World Cancer Day, to continue to inspire our workforce during a difficult period whilst also reassuring our patients that we were still here and ready to give them the best care possible.

Walsh kicked off proceedings for the work in December 2020 with a creative workshop, to understand the thoughts, feelings and reality of those working in, and affected by cancer, including cancer managers, researchers, doctors, surgeons, patients and commissioners to name just a few.

"The workshop allowed me to engage with other people, something I was missing whilst shielding – and on something very special. It was emotional. The work that everyone across the patch does for cancer isn't just a paperwork exercise – we all have this one thing which unites us."
Vanessa, GM Cancer Service User

A video was produced to go alongside Tony's poem, filmed at Rochdale Infirmary and The Christie NHS Foundation Trust – who both played instrumental roles in the Cancer Surgical Hub model established during the pandemic.

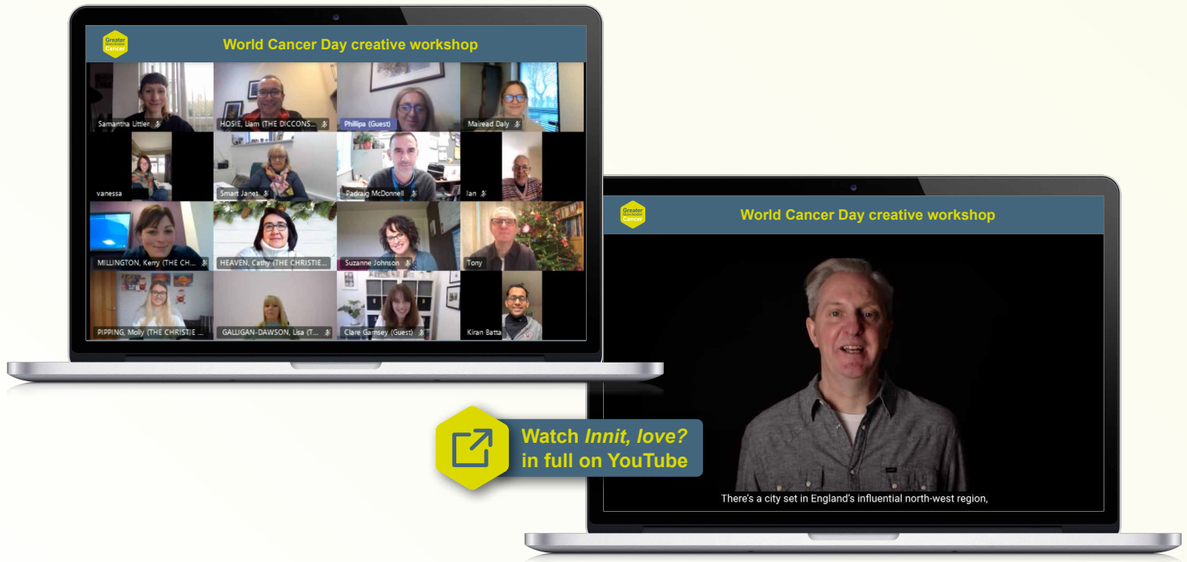
The poem, entitled Innit, Love? was launched on World Cancer Day and can be watched in full on YouTube. It has received thousands of views and overwhelmingly positive feedback.

It sparked a huge reaction online, with hundreds of likes, comments, shares via social media platform and thousands of views – which continue to increase to this day.

Media response

The piece was picked up by BBC Radio 5 Live, in an interview segment with Tony lasting a full 9 minutes. Broadcast outlets such as BBC Radio Manchester and Hits Radio, in addition to various online print titles also covered the story. Wigan GP Liam Hosie, who took part in the creative workshop, was also interviewed for these pieces and was able to highlight key messages to patients - that primary care is open and those with symptoms should contact their GP.

Local teams were also able to use the story within internal communications, and to promote work done locally to support cancer services during the pandemic.



Virtual Cancer Week

In May 2021, in place of the usual Greater Manchester Cancer Conference, the Alliance held it's first 'Virtual Cancer Week'.

The aims of the week were the same to that of our usual annual conference: to bring people together from across the cancer system to reflect, educate, inspire and motivate.

Agenda and format

The event considered topical themes and projects with a blend of both research and clinical elements. These were delivered in a range of formats, from keynote addresses, to panel discussions, seminars and sessions focussed on services, research and/or education.

A full week's online programme was developed, with each day linked to a key theme:

- Living well
- Early diagnosis
- COVID recovery
- International impact
- Engaging communities

Stakeholders from a wide range of organisations, professions and specialisms supported the development and the delivery of our agenda, which also incorporated our User Involvement Representatives throughout.

Poster submissions were also welcomed and these were displayed in our online gallery, along with an area of charities and local voluntary sector organisations to display information about their services.

The event was also supported by sponsorship and we would like to thank the Manchester Academic Health Science Centre (MAHSC), Lilly Oncology and EUSA Pharma for their contributions to support the delivery of this year's event.

Greater Manchester Cancer

Virtual Cancer Week

Monday 24th – Friday 28th May

VCW2021 | @GM_Cancer | Greater Manchester Cancer

Sessions are open to all registrants but classified as follows for reference
Keynote | Service | Public | Research | Education

	Monday 24th Living Well	Tuesday 25th Early Diagnosis	Wednesday 26th Covid Recovery	Thursday 27th International	Friday 28th Engaging Communities
9.15	Welcome	Welcome	Welcome	Welcome	Welcome
9.30 - 10.15	GM Cancer: who we are and what we do	The Challenges and Future of Early Diagnosis	COVID-19: what have we learned and where are we	Global Challenges, Manchester Solutions	Time to Engage with Communities
10.30 - 11.15	Aspects of Living With and Beyond Cancer	Innovation in Early Detection	Innovation in Digital & Patient Reported Outcomes	Global Challenges, Manchester Solutions (continued)	Screening Update: How can we improve our reach?
11.30 - 12.15	Smoking Cessation	GM Developments in Early Diagnosis	COVID Recruits – The Cancer Workforce of the Future		Inequalities series in palliative care / What is User Involvement
12.30	Prehab Exercises- 15 minutes exercise and mindfulness sessions at your desk or in your chair: led by the Prehab4Cancer team				
13.30 - 14.15	GP Palliative Care & Symptom Management	Faecal Immunochemical Test (FIT) in Suspected Bowel Cancer (GatewayC LIVE)	The GM Lung Cancer Pathway (GatewayC LIVE)	'Cancer-Related Fatigue' and Fatigue Management	LGBTQ+ and Cancer Care
14.30 - 15.15	Digital Approaches to Self Managed Care	Manchester Breast Centre Session	COVID legacy in Radiotherapy	Show & Tell: Proton Research / Advances in Palliative care services	Staying focused on the long-term
15.30 - 16.15	Getting Emotional Care Right / 15.00 - 16.00 GM Cancer - Public Cancer Board	At The Close: The Best Timed Prostate Pathway Project	How the Prehab4Cancer and recovery programme has supported 1000 cancer patients in GM during the COVID pandemic	Leadership Session	
16.15 - 17.00	*These are promotional sponsored sessions by Lilly Oncology. Attendance is restricted to healthcare professionals. Products may be discussed* (Lilly)		(Lilly)		

This event is supported by the following companies. They have had no input into main the agenda, topics or speakers. Company input is limited to the select sponsored session.

Manchester Academic Health Science Centre | Lilly Oncology | EUSAPharma | GMCA Greater Manchester Combined Authority | NHS in Greater Manchester

The week in figures

1,750
registered delegates

4,161
delegates watched live content

1,326
from Greater Manchester & East Cheshire, and **479 from outside GM**

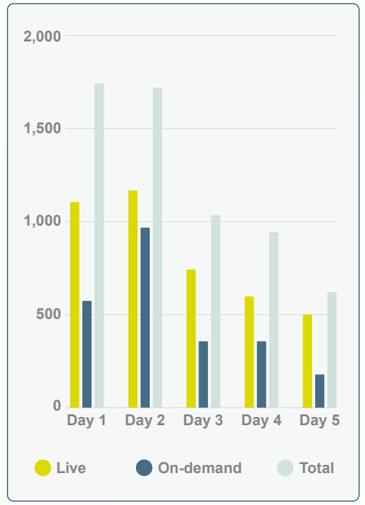
1,598
delegates watched content on-demand

Delegates came from a wide variety of professions and specialisms including nurses, service managers, people affected by cancer, charity representatives, doctors, advanced healthcare practitioners, researchers and administrative roles.

Visual Minutes

Our sessions and the key reflections and comments from them were summarised for each day in Visual Minutes.

Viewing across all 5 days



Lunchtime movement and mindfulness

The team recognised that virtual events can often lead to long periods of sitting in one position which can be tiring for delegates. Throughout the week's agenda, our Prehab4Cancer team provided lunchtime sessions in exercise and mindfulness to refresh our delegates and promote movement – including activities such as stretching and Tai Chi. Each session lasted approximately 15 minutes and was led by a different trainer from our Prehab team, and 250 delegates tuned in to join in.

Feedback

Feedback from the event was overwhelmingly positive. In addition to the high viewing and registration figures, 98% of delegates surveyed would recommend the sessions that they attended. Our social media engagement was also high, with hundreds of positive comments using our event hashtag **#VCW2021**.

Thank you

The team recognises the significant number of contributions to this event from a wide range of stakeholders and organisations from across the Greater Manchester cancer system and would like to help everyone for their input and support in delivering this event, with particular acknowledgement of the event's planning committee:

Dr Cathy Heaven, Director of Education, Greater Manchester Cancer

Molly Pipping, Virtual Cancer Week Project Manager

Joe Clarke, Communications Manager, MCRC and CRUK Manchester Centre

Anna Perkins, Communications and Engagement Lead, GM Cancer

Patrick Fahy, Service User Representative

Cancer Academy

Urology Academy
Greater Manchester Cancer

In 2021, the Cancer Alliance was awarded funding to pilot a 'Cancer Academy' model, designed to address the need for sustained investment in staff development and to standardise training and education for the non-medical workforce.

The academy has the overarching aim of ensuring a sustainable lifelong learning model for the cancer workforce which will ultimately improve care for people affected by cancer and reduce variation in service provision across the system.

The Academy is currently being piloted in urology in the first instance however, there are already plans to expand to other pathways and develop cross cutting education for healthcare professionals working across all care settings so that it can develop into the cancer 'education hub' for GM.

Upskilling the cancer workforce

In 2020/21, GM Cancer alliance was awarded funding from HEE to support upskilling different professional groups including:

Cancer nurses - £172,553 was awarded to support the upskilling of the cancer nursing workforce in GM. This allowed a total of 49 CNS' and 11 chemotherapy nurses to access training grants to support training in an area of service need, including training in psychological level 2, advanced communications, Masters modules, palliative care and many more topics.

To build on this the alliance successfully bid for funding to lead a North West CNS capability framework to improve recruitment and retention of a workforce in crisis. The success of this project led to the development of the National ACCEnD (Aspirant Cancer Career Education Development) programme, which aims to provide guidance and direction on the knowledge, skills and capabilities required by all nurses and allied health professionals who care for people affected by cancer. The ACCEnD programme will seek to address and provide solutions to key issues that challenge the cancer workforce both now and into the future.

Other areas of funding to support upskilling the cancer workforce included training grants to increase the number of reporting radiographers and Clinical Endoscopists across GM.

User Involvement

User Involvement (UI) Representatives continue to form an integral part of the Greater Manchester Cancer Team. They support our teams to ensure the patient voice is heard and that we continue with our aims to improve the experiences and outcomes of people affected by cancer in Greater Manchester.

Throughout the last two years and despite the pandemic, our User Involvement Representatives have continued to make valuable contributions to the work of our Pathway Boards, transformation programmes and projects, along with participating in surveys, producing educational resources and featuring in podcasts, events and awareness campaigns. Many examples feature throughout this report.

They have continued to support our work despite many facing personal anxieties around COVID-19, undergoing treatment and/or being required to shield during this time.

A huge thank you from the Greater Manchester Cancer Team to our User Involvement Representatives for your support.

Greater Manchester Cancer **Podcast**

Podcast series

In 2021, the Cancer Alliance launched its own podcast to keep our network up to date with the latest updates in clinical practice and research.

Each episode focuses on a different topic and includes a range of interviews, including clinicians, researchers and people affected by cancer. The podcast is hosted and produced by You, Me and the Big C's Steve Bland.

Episodes to date:

Episode 1
Cancer and COVID-19
Steve and guests discuss the impact of COVID-19 on cancer services in GM and how services were maintained throughout the pandemic

Episode 2
The Future: The Galleri Trial
Steve learns more about the new cancer screening trial which launched in GM in October 2021 and what this could mean for early diagnosis in the future

Episode 3
Understanding the HPV vaccine
Following a Lancet study claiming the HPV vaccine had significantly reduced incidence of cervical cancers, Steve explores what this could mean for head and neck cancers with his guests

Episode 4
Your inspiration: What drives YOU to make a difference?
Steve speaks to a range of individuals across the cancer system to learn more about their roles and how personal connections to cancer have inspired them to make a difference to cancer outcomes

Episodes are published every 6 to 8 weeks with new episodes in the pipeline for 2022.

You can find our podcast in all the usual podcast places including Apple Podcasts and Spotify. Search for 'The Greater Manchester Cancer Podcast'.

Reflections

Reflecting on the last two years as Chairs of the Greater Manchester Cancer Board, two things have been clear: both the scale of the new challenges we have faced as a cancer system and the dedication of our teams in Greater Manchester to overcome them.

We set out in 2020 to continue building on the progress made in the previous year, knowing that we still had lots more to do to improve things for our patients. The response from our teams when the situation changed dramatically in March 2020 to a period of uncertainty and complexity has been commendable, with our system pulling together like never before.

Not only were cancer services able to be maintained safely owing to the leadership of our Cancer Alliance team, but our teams were also able to continue progressing a number of other key projects noted in this report, in order to continue to transform our cancer services here in Greater Manchester. We would like to the Cancer Alliance leadership team and the rest of our cancer system for showing true collaboration and resolve during this time.

It is important to note that whilst we all recognise the challenges and strain on our health care teams over the last 2 years, we cannot underestimate the impact this time has also had on our patients, many of whom have had to face their cancer on top of the stressors of the pandemic and have had to navigate diagnosis, treatment and living with their cancer all the while.

We know the challenge is not over and there is still much work to do to improve outcomes and experiences for our patients in Greater Manchester. What is clear from the pages of this report is the commitment of all of our staff and patients, regardless of the challenges we may face, to collaborate, innovate and make things better for people with cancer in our region.

We look forward to working together with the Cancer Alliance team and our colleagues across the system to continue to deliver for our patients over the next 12 months.

Roger Spencer
Anita Rolfe
Andrea Green
Co-Chairs of the Greater Manchester Cancer Board

Keep in touch

We always welcome comments, feedback and opportunities to collaborate with partners to improve cancer services and the experiences of our patients.

You can find us in the following places

gmcancer.org.uk

greatermanchester.cancer@nhs.net

Follow us on social media

@GM_Cancer

Greater Manchester Cancer

Greater Manchester Cancer

Greater Manchester Cancer Spotify | Apple

YouTube **Greater Manchester Cancer**

gmcancer.org.uk

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Greater Manchester Cancer

Greater Manchester
Cancer Conference 2022

Cancer Board: Paper for information

18-19 October 2022
Hybrid (in-person and online)
Hilton Manchester Deansgate

Greater Manchester Cancer Conference & Awards 2022

Overview

Following two successful conferences in 2018 and 2019, in addition to a Virtual Cancer Week and World Cancer Day event in 2021, the Greater Manchester Cancer Alliance team are hosting a **hybrid** conference on Tuesday 18 and Wednesday 19 October 2022. This will take place at **Hilton Manchester Deansgate**.

The theme of our agenda this year is **Equality, Innovation & Collaboration** and each session will address these points. Our agenda is co-produced with representatives from clinical services, research and people affected by cancer.

A full agenda will be released in the coming weeks.

Key points:

- Circa 450 in-person attendees per day
- Circa 750 virtual attendees per day (event will be live streamed)
- Local and national speakers, including NHS England National Cancer Team and the Mayor of Greater Manchester (TBC)
- Blend of keynote sessions, sofa panel discussions and breakout seminars
- Attendees include clinicians, researchers, commissioners, cancer managers, non-clinical support staff and people affected by cancer, in addition to charities and other relevant organisations.
- Poster competition and prizes
- Charity village on-site, signposting to support services available for people affected by cancer
- Dedicated patient lounge available in a private space away from the main event hall

More information available at www.gmcancer.org.uk/gmcc22

Register for tickets: https://gmcc22.eventbrite.co.uk/

Awards

In addition to our Annual Conference, this year we launch the first Greater Manchester Cancer Awards. We want to celebrate those to have the dedication to go above and beyond every day to improve outcomes and experiences for people affected by cancer here in Greater Manchester. Awards are open to teams across Greater Manchester

including NHS staff, research teams, VCSE sector organisations, public health teams and other organisations.

Categories include:

- Outstanding Care Award
- Greater Manchester Collaboration Award
- Commitment to Equality Award
- Research Award
- Educational Impact Award
- Innovation Award

Our judging panels are yet to be finalised but will include people affected by cancer in addition to key stakeholders from across Greater Manchester. Our User Involvement Programme will also have the opportunity to vote for their favourite entry from those shortlisted, as an additional 'Patient choice award' (name to be confirmed).

More information and entry forms are available at: **www.gmcancer.org.uk/awards**

Key dates:

- Deadline for entries: Wednesday 31st August
- Shortlist announced: Mid-September
- Winners announced: Tuesday 18th October 2022. A small awards ceremony will take place for shortlisted teams at The Hilton on the evening of 18 October and will include light refreshments and entertainment.