Greater Manchester Cancer

NHS Greater Manchester Integrated Care

GM Cancer – Cancer Board Agenda

Meeting Time and Date: Monday 27th March 2023, 15:00-17:00
Venue: The LifeCentre, 235 Washway Road, Sale, M33 4BP
Meeting Chair: Roger Spencer

	Item	Type	To	Lead	Time
1	Welcome and apologies Minutes from previous meetings - 28th November 2022 - 30th January 2023 Action log review	Verbal Paper 1 Paper 2 Paper 2	- Approve Approve Update	Roger Spencer	5'
2	Introduction to Cancer Alliance	Presentation	Update	Roger Spencer Claire O'Rourke Dave Shackley	15'
3	ICB Leadership and Governance review update Carnall Farrar	Presentation	Update	Lisi Hu	15'
4	System Escalation and Recovery. Faster Diagnosis & Operational Improvement and Treatment	Verbal Presentation Paper 3	Update	Claire O'Rourke	15'
5	Early Diagnosis	Presentation	Update	Ali Jones	15'
6	Papers for information: - Quarter 3 Planning Return - 23/24 Delivery Plan Submission - Risk Register - Finance Update - Personalised Care Update	 Paper 4 Paper 5 & 6 Paper 7 Paper 8 Paper 9	 Update Update Update Update Update	 Alison Armstrong Alison Armstrong Alison Armstrong Becky Fry Freya Driver	 -
7	AOB	-	Discuss	All	40'

The next meeting is scheduled for Monday 15th May 2023 at the Salford Royal Mayo Building, Salford Royal, Stott Lane, Salford, M6 8HD

Greater Manchester Cancer

NHS Greater Manchester Integrated Care

Greater Manchester Cancer Board
Minutes and Actions

Meeting time and date: Monday 27h March 2023 15:00 – 17.00
Venue: The Life Centre, Sale

Members present		
Name	**Role**	**Organisation / Representation**
Roger Spencer (RS)	Co-Chair / Chief Executive	The Christie NHS Foundation Trust
Dave Shackley (DS)	Medical Director	GM Cancer Alliance
Claire O'Rourke (COR)	Managing Director	GM Cancer Alliance
Alison Jones (AJ)	Director of Early Diagnosis and Commissioning	GM Cancer Alliance
Alison Armstrong (AA)	Associate Director	GM Cancer Alliance
Suzanne Lilley (SL)	Workforce & Education Programme Director	GM Cancer Alliance
Sarah Taylor (ST)	GP/ Primary Care Lead	GM Cancer Alliance
Leah Robins (LR)	GM Trust Chief Operating Officer	Northern Care Alliance NHS Foundation Trust
Rob Bellingham (RB)	Director of Primary Care and Strategic Commissioning	GM NHS Integrated Care
Roger Prudham (RP)	Lead Cancer Clinician representative	Northern Care Alliance NHS Foundation Trust
Ed Dyson (ED)	Director of Performance	NHS Greater Manchester Integrated Care
John Wareing (JW)	Director of Strategy	The Christie NHS Foundation Trust
Sally Parkinson (SPa)	GM Finance	The Christie NHS Foundation Trust
Lisa Spencer (LS)	GM Trust Director of Strategy representative	Northern Care Alliance NHS Foundation Trust
Anita Rolfe (AR)	Co-Chair / GM Place Lead Representative	Stockport CCG
Susannah Penney (SP)	Associate Medical Director	GM Cancer Alliance
Freya Driver (FD)	Director of Personalised Care	GM Cancer Alliance
Denis Colligan (DC)	GP / Macmillan Representative	Macmillan Cancer Support

In attendance		
Name	**Role**	**Organisation/Representation**
Sue Sykes	Senior Programme Manager / RDC Programme Lead	GM Cancer Alliance
Rebecca Fry	Head of Financial Management - R&I, Education, Partnerships and Projects	The Christie
Stella Ruddick	Senior Team Administrator	GM Cancer Alliance
Sarah Carr	Senior Team Administrator	GM Cancer Alliance

Lisi Hu	Consultant	Carnall Farrar

Apologies		
Name	**Role**	**Organisation**
Manisha Kumar	Medical Director	NHS GM Integrated Care
Janelle Yorke	Chief Nurse	The Christie NHS Foundation Trust
Rob Bristow	Director / Research Representative	Manchester Cancer Research Centre
Claire Trinder	Director of Research Operations and Strategy	University of Manchester
Janet Castrogiovanni	Managing Director	Greater Manchester Primary Care Provider Board
Victoria Cooper	Lead Cancer Nurse	Northern Care Alliance NHS Foundation Trust
Mary Flemming	Chief Operating Officer	Wrightington, Wigan and Leigh NHS Foundation Trust
Jane Pilkington	Head of Public Health	Population Health
Nabila Farooq	Service User Representative	GM Cancer Alliance
Lisa Galligan-Dawson	Performance Director	GM Cancer Alliance
Vicky Sharrock	Programme Lead	GM Provider Federation Board
Martyn Pritchard	Managing Director	GM Provider Federation Board

1. Welcome and Apologies	
Discussion summary	RS welcomed everyone to the meeting and noted the apologies received. RS asked that AA be informed of any further apologies or changes in representation. RS asked if the board were happy to approve the minutes from the November and January GM Cancer Board Meetings, to which all attendees gave their approval. RS enquired after comments on the action log, to which there were none. He added that all actions had been addressed and closed since the last board meeting.
Actions and responsibility	Nil of note.

2. Introduction to Cancer Alliance	
Discussion summary	COR gave an introductory presentation on the GM Cancer Alliance to inform the representative from Carnall Farrar further on the organisation and its purpose. COR added that the GM Cancer Alliance approach was to go over and above what was required by the planning guidance and the organisation will be developing a 5-year plan to further evolve and innovate. DS commented on the importance of clinical engagement, as well as engagement with primary and secondary care.
Actions and	Nil of note

responsibility	

3. ICB Leaderships and Governance Review Update – Carnall Farrar	
Discussion summary	RS introduced Lisi Hu (LH) from Carnall Farrar and thanked her for attending the meeting. LH gave a presentation on the current review of the ICS Leaderships and Governance. LH explained to the attendees that the purpose for her joining the meeting was to collect responses on the following points: • How do you interpret the roles and responsibilities of the Cancer Board? • What are your reflections on the ways of working with the other elements of the ICS, for example the ICB / Providers / Locality teams? • What does success look like for this System Board? RS thanked LH and the GM Cancer Alliance staff for working together to facilitate the requirements of the review. He then invited the attendees to give feedback on the questions. LH thanked the attendees for their input. COR added that a list of the feedback would be shared shortly with LH.
Actions and responsibility	List of feedback to be shared with LH from Carnall Farrar

4. System Escalation and Recovery / Faster Diagnosis & Operational Improvement and Treatment	
Discussion summary	COR explained that she would be giving the Performance Update on behalf of LGD who was unable to attend the meeting. COR noted that this presentation was based on the constituent standards for Cancer; Faster Diagnosis Standard (FDS) and the 62-day backlog. Operational Performance for Cancer in Greater Manchester (GM) is challenged due to difficulties in the capacity to deliver cancer services against over competing pressures such as industrial action, workforce issues, etc. COR explained that diagnostics are currently difficult due to the lack of access to appropriate and timely Cancer diagnostics, not just radiology but histopathology across all diagnostic pathways. Due to the number of patients, there is a sustained level of 120%+ referrals coming in and all those patients need a diagnostic to move through a pathway. There is congestion in these pathways as well as elective surgeries and everything else that requires a diagnostic. There are significant workforce shortfalls across GM Cancer treatment, which affects the operational performance. Out of the regions, GM was hit most significantly by COVID-19 and GM was already moving into a recovery plan for Cancer even before the pandemic struck. COR added, due to the hard work from all involved, the current position is positive given the circumstances. COR explained that there are two GM providers in the tiering system (MFT and NCA) and therefore RP and SP sit on the weekly tiering calls. These include a line-by-line micromanagement of constituent standards and performance, particularly on backlog. There will be a focus, from April, on the Faster Diagnosis Standard on these calls. GM is at 63% with a trajectory of 71% against the standard, however the smaller providers such as Stockport and Tameside have made significant

	improvements. COR commented that the challenge pathways are Skin (due to the number of referrals for cancer and non-cancer), gynaecology (cancer and non-cancer) and lower GI and urology. She added that there are clinicians leading on each of these programmes of work, hence the benefit of having a pathway board. The GM region hit target for Breast and Lung which took significant work, especially on pathway improvements which is now showing in the delivery of the FDS. The backlog numbers are still high with the region's trajectory at 761. The national team have given leeway on the trajectory, but providers are asked to have stretch targets for this year to clear the cancer backlog which they have all agreed and signed up to. This was submitted in the2023/24 plan. The issues with MFT and NCA are purely due to volumes and as the biggest providers they also help with mutual aid across the system. They are a victim of their own success, supporting other providers during the pandemic. There are issues with Tameside regarding teledermatology as it is a small hospital, and if consultant goes off on leave, the service is impacted. COR noted that the GM region does more Cancer surgery than in the rest of the UK. The current stretch target is 370 cancer surgeries a week with the current figure at 270 but this is because of the industrial strike action over the last few months. There is additional elective hold capacity at the Christie and across the other providers who charge GM to do more cancer surgery. There are still over a thousand patients classed as P2 (urgent) waiting for surgery; this is down to system pressures due to limited elective capacity within the system and the number of patients who are in hospital who don't need to be there. COR reconfirmed that all providers are engaged with the performance aims. COR and LGD attend the Chief Operating Officers (COOs) meeting and present at the Gold Command weekly; and reports are taken every other week to the GM Provider Federation Board (PFB) by RS. The GM Cancer Alliance reports to the National Cancer Team on an alternate week basis and there is a North West Cancer Board joined by the other Cancer alliances each week to discuss issues and best practice, and to offer mutual aid. COR referred to the work being done by the team at the point of referral in primary care which is making a significant difference in how we educate GP colleagues on appropriate referrals. There are many projects taking place to make key improvements but there is still some risk in the system. SP explained that operational performance is exposed to a high level of scrutiny. There are backlog and recovery meetings where the GM Cancer Alliance team work with teams across the region to discuss challenges and offer support to reduce backlog and increase operational performance.
Actions and responsibility	Nil of note

5. Early Diagnosis	
Discussion summary	AJ presented her slides and noted that she had selected some key updates and highlights from the last few months. Plans for this year's work were submitted for 2023/24 in line with the national expectations. The plans submitted for Early Diagnosis were developed with a significant number of partners in the GM system. AJ referred to the Clinical Decisions Support Tool which was required to have 100% coverage. They worked with the Data Quality Team, which is now part of NHS Integrated Care, to design and roll out

	the THINK CANCER tool which has been rolled out to most of the practices in GM. Nearly 500 practices will have the tool in place by the end of this week. AJ noted the ongoing programme of education commissioned from Gateway C and added that MP and SL have worked to expand the exposure of the work of the Cancer Academy. AJ referred to the Primary Care Network (PCN) engagement event on the 2nd March which was a full-day planning session on working together with Primary Care. There were over 80 attendees who gave positive and constructive feedback along with a wealth of information to take into the next 12+ months. She explained that in line with national planning guidance they have identified some resource and process to harness innovations to evolve work with Cancer over the next 2 years. AJ updated that the FIT referral figures had improved since her slides were created, and they are now at 65.8% for GM which is higher than national level. She added that these figures are not fully conclusive, as the referrals form still needs to be fully embedded in GM. She explained that, regarding the Targeted Lung Health Check (TLHC), there was continued work with the partnership in GM to roll this out at PCN level as well as at locality level. At the programme board, it was agreed that the next phase of roll out will move into the Wigan locality. Previously it this project was seen in Salford, Manchester, and Tameside. AJ noted that the appointee for the 10GM role was a strong candidate who will be the formal link between the GM Cancer Alliance, localities, and the voluntary sector in GM. There is a grant funding process available where some voluntary organisations can secure small amounts of funding to identify people earlier in their cancer diagnosis which will be a key step in their role in the voluntary sector. Part of this person's role will to be liaise with Cancer Board. She commented on the new Health Inequalities Programme Board as well as the strategy and action plan which were pulled together with input from many GM stakeholders. AJ added that there is a new clinical lead for Health Inequalities who will chair the board. RS referred to the FIT update and explained that it was difficult work and gave his congratulations on the improvement. STa added that this result was a clear example of impressive collaboration and referred to RP's help with clear messaging and the relationship with Primary Care. RP noted the 65% FIT figure and how, as 8% of the fit tests are incomplete for a variety of reasons, the uptake is higher than the figure noted. RS noted that the Health Inequalities Programme Board will present to the GM Cancer Board in May to discuss developments. He hoped that the GM Cancer Board members would prioritise attending the meeting to hear this update. LS enquired, ahead of the presentation in May, if there are any opportunities or requirements to link in better with other parts of the GM system regarding Health Inequalities. AJ responded that in the early days, finding a place to link in to was difficult as many stakeholders have their own inequalities work. She confirmed that they have managed to get representatives to be part of the board from many localities and organisations to make a productive group. DS noted that the alliance has focused on who they can link to and the evidence-based programmes that can be pushed into the system. One of the areas to work on is to connect with research into inequalities. He commented on the inequalities of the patients that are offered and uptake research. RP noted for the attendees to consider the work required to get diagnosis earlier, which can take a long time for the results to become apparent. Considering variation around Health inequalities, this topic needs to be top of the agenda and thread through all the work the GM Cancer Alliance does It would be good to have the Health Inequalities Board minutes circulated to all Pathway Boards to

	improve oversight of that work. RS referred that he chairs the Early Diagnosis and Screening Sub-group for the National Cancer Board. The expert advice from that group is to develop innovative approaches but also implement things that are known to work, which are not being implemented in the best way currently.
Actions and responsibility	Health Inequalities Board minutes to be circulated to all Pathway Boards for information.

6. Papers for Information	
Discussion summary	RS asked for AA to go through the papers for information circulated in advance of this meeting. **Quarter 3 Planning Return** AA noted that the Planning Return shows what will be delivered on this year's plan. **23/24 Delivery Plan Submission** AA suggested for the attendees to read the Delivery Plan Submission. She explained that the planning pack was issued just before Christmas. The response on this first draft has now been received and is currently being reviewed. **Risk Register** AA explained that this was a paper for information, and noted the top risk was related to workforce. **Finance Update** AA noted that RF attended the session to answer any questions. The update included information on end of year funding and expenditure. **Personalised Care Update** AA noted that this update would usually be presented but there was insufficient time in the meeting for this to take place. She noted FD is available to take questions if required.
Actions and responsibility	Nil of note

7. AOB	
Discussion summary	AR requested responses on the GM Quality Strategy which will be circulated after the meeting. She added that there are things included which are of a particular interest from a cancer perspective. RS gave his thanks to the attendees are reconfirmed that the next meeting would take place on Monday 15th May in the Mayo Building at Salford Royal.
Actions and responsibility	GM Quality Strategy to be circulated for feedback.

The next meeting is scheduled Monday 15th May, 15.00 – 17.00 at Salford Royal Mayo Building, Salford Royal, Stott Lane, Salford, M6 8HD

Greater Manchester Cancer

NHS Greater Manchester Integrated Care

Action Log

Prepared for the 27th March 2023 GM Cancer Board

Log No.	AGREED ON	ACTION	STATUS
01.23	Jan 2023	GM Cancer admin team to share minutes of November22 and January23 cancer board meetings together.	Closed
09.22	Jan 2023	• Planning guidance and cancer alliance planning pack to be shared with board members. COR to update the board on the cancer alliance delivery plans at the next meeting.	Closed
10.22	Jan 2023	LGD to provide updated performance figures once updated at national level.	Closed
11.22	Jan 2023	Cancer alliance to consider producing infographics to detail: • Financial structures within the system Key principles in delivering Cancer Waiting Time Standards	Closed – In progress
12.22	Jan 2023	Answer Cancer Impact Report to be shared with board members.	Complete. Closed
01.23	March 2023	List of feedback to be shared with LH from Carnall Farrar	Complete. Closed
02.23	March 2023	AJ to circulate Health Inequalities Board minutes to the Pathway Boards for information.	Closed – In progress
03.23	March 2023	GM Quality Strategy to be circulated for feedback.	Complete. Closed

GM Cancer Alliance, our Role in Cancer Care

27th March 2023

Claire O'Rourke, Managing Director GM Cancer

Greater Manchester Cancer Alliance

- **Clinically-led** alongside patients as experts with pathway boards leadership
- **Whole pathway**: Prevention to EoLC
- System-wide agreed comprehensive **delivery plan**
- **Integrated** with research/ education
- Connected experts/ **single shared community**
- **Being innovation** in cancer care

Greater
Manchester
Cancer

Cancer Alliances

- **Cancer Alliances are unique** within NHS systems

- **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**

- **Cancer Alliances were established in 2016, following the recommendations of the Independent Cancer Taskforce.** 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.

Greater Manchester Cancer

Cancer Alliance responsibilities

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 Rapid Diagnostic Centres
- **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
- **Speed up cancer pathways**, reducing waiting times and improving operational performance.

Greater Manchester Cancer

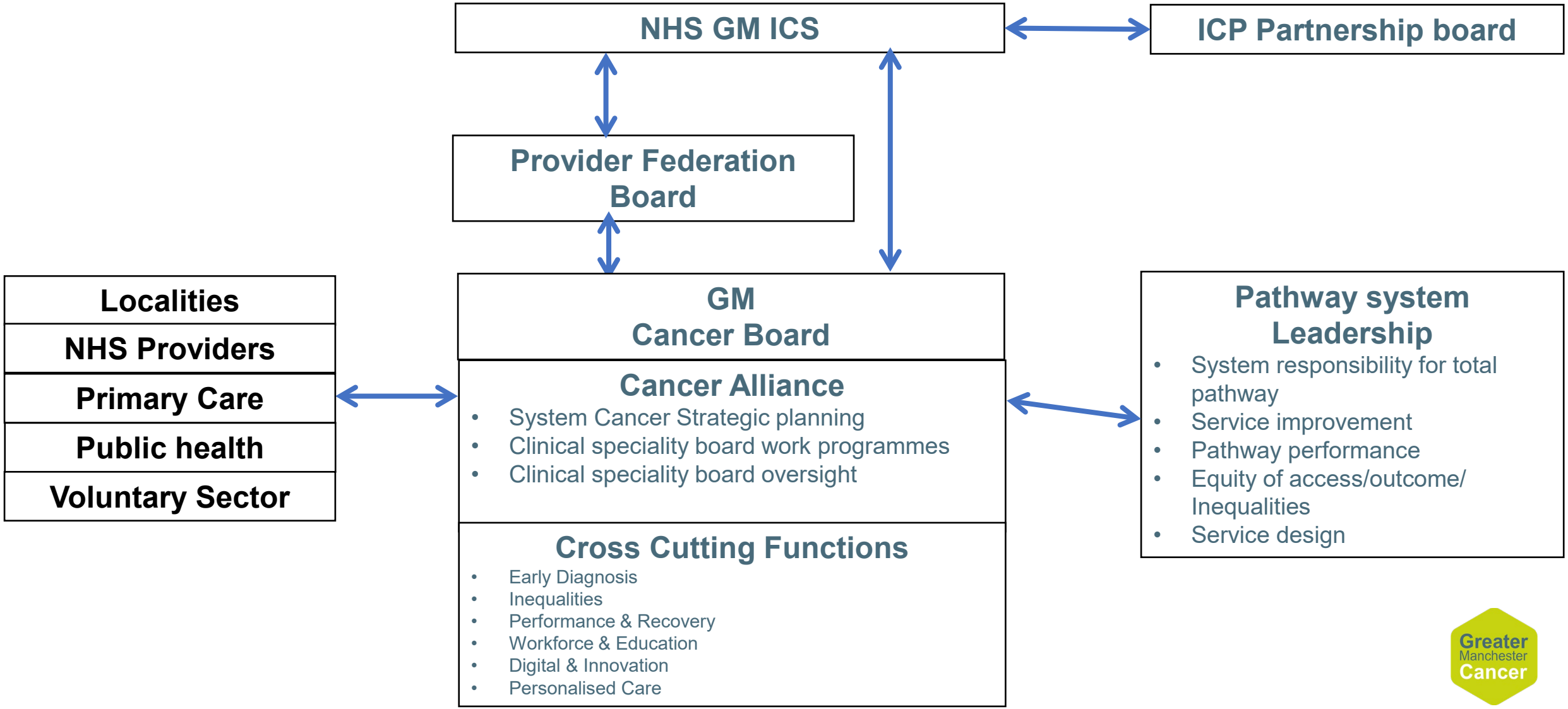
ICS and Cancer Alliance relationship

‘Cancer Alliances already lead the planning and delivery of cancer services and their improvement within their local systems. The Cancer Alliances will therefore continue to undertake these roles due to’:

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

Greater Manchester Cancer

GM Cancer System



Greater Manchester Cancer

Long Term Plan Aims

Through delivery of the **NHS Long Term Plan** we will transform cancer care and outcomes so that from 2028:

3 in 4 (75%) of cancers will be diagnosed at stages 1 and 2

55,000 more people per year will survive their cancer for five or more years

Greater Manchester Cancer

GM Cancer Alliance innovations

THE CURE PROJECT
CURING TOBACCO ADDICTION IN GREATER MANCHESTER

Nutrition
PREHAB 4 CANCER
GREATER MANCHESTER
Exercise
Wellbeing

Greater Manchester Cancer

Innovations to improve cancer performance

- ***Targeted Screening review***/ growth of TLHC/increasing GRAIL and genomics medicine work
- Expansion of ***smoking reduction programme*** and ***pre-hab*** work
- Extensive programme of work on **Early Diagnosis**
- **GP education** programme/ referral management
- ***Single queue diagnostics***
- ***Breast service*** referral review/ breast pain and radiology
- ***Lung joint clinic*** – High risk / complex clinic expected to reduce 7 pathway days
- ***Oncology outpatient consolidation*** – Single queue reducing variation in waiting times
- ***Expansion of Green Site capacity*** – 10 extra cancer surgical lists per week
- **Implement new Best timed pathways**: pathway reform across several Tumour sites
- ***Review of Cancer Diagnostics*** to support elective programme.
- Extensive ***cancer workforce plan and strategy***

Greater Manchester Cancer

Next Steps for GM Cancer…

- Continue to support system recovery of Cancer Services
- Delivery of planning guidance and supporting GM delivery plans
- Support cancer clinical teams to be innovative
- Delivery of funded plans to support innovation and transforming cancer services
- Continue to addressing unwarranted inequalities and variation in respect of access, quality and outcomes across GM and across pathways
- **Always be the advocate for our Cancer Patients**

Greater Manchester Cancer

Greater Manchester ICS: Leadership and Governance Review

GM Cancer System Board
Group Discussion
27 March 2023

Controlled

The leadership and governance review is positioned to complement the diagnostic that is currently taking place

- GM has seen **declining performance against constitutional standards** and a **deteriorating financial position.** A **diagnostic has been initiated** to identify how the ICS should respond to these challenges
- The **leadership and governance review** will assess whether the system arrangements are appropriate to deliver on the outcomes of the diagnostic

- We are reviewing the arrangements that provide the **structures for oversight**, **delivery** and **transformation** across the system
- We want to understand **how effectively the current arrangements work**, including **leadership**, **decision-making structures**, **resourcing** and **culture**
- We will do this through a range of engagement methods including **interviews**, **group discussions** and a **survey**
- We will feedback our findings at a **system leadership event** in late April, providing the system leaders with an understanding of the **challenges** and seek to **align around the priorities for action**
- The outcomes of the review will be set out in **a final report in late April**

We are engaging with leadership across the system through multiple methods

1 1:1 engagement

We will continue to undertake c.30 minute interviews with:

- All members of the ICB team including non-executives
- Co-Chairs of the ICP
- All Trust Chairs and CEOs
- All Place-based Leaders and Locality Board Chairs
- The MD of the Provider Federation Board
- The Chair of the Primary Care Board
- Members of NHSE

2 Survey

We will issue surveys to all **Trust Executive teams** and **Locality Board members** to capture views on the key priorities and the effectiveness of the leadership and governance arrangements

3 Group discussions

We will facilitate **28 discussions** through existing forums, which include:

- Trust Executive teams
- Provider Federation Board Executive team
- System Boards
  - **Cancer**
  - Clinical Support Services
  - Elective
  - Mental Health Partnership
  - UEC
- Primary Care Board
- Locality Board members

4 System leadership session

Findings from the review would be shared at this **in-person session at the end of April** and we will facilitate system leaders to **co-design potential changes or solutions** to improve the current arrangements.

The session will involve:

- ICB members
- CEOs from each provider
- Locality leaders

Today we want to explore your views on the System Board and its position in the wider GM architecture

- How do you interpret the roles and responsibilities of the Cancer Board?
- What are your reflections on the ways of working with the other elements of the ICS, for example the ICB / Providers / Locality teams?
- What does success look like for this System Board?

Faster Diagnosis & Operational Improvement

Lisa Galligan-Dawson
Director of Performance

Operational Performance

CURRENT PERFORMANCE

FDS

Jan -63.4%
Trajectory
71.52%

Breast & Lung achieving at GM level

Key focus Skin, LGI. Gynaecology

Backlog

Feb -1270
Trajectory
1027

Significant Improvement MFT & NCA. Concern around Sustainability (finance)

Tameside starting to reduce.

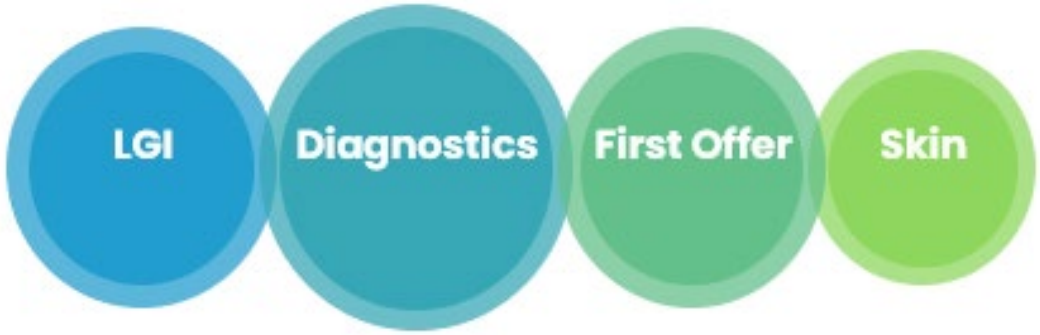
First Treatments

93%*

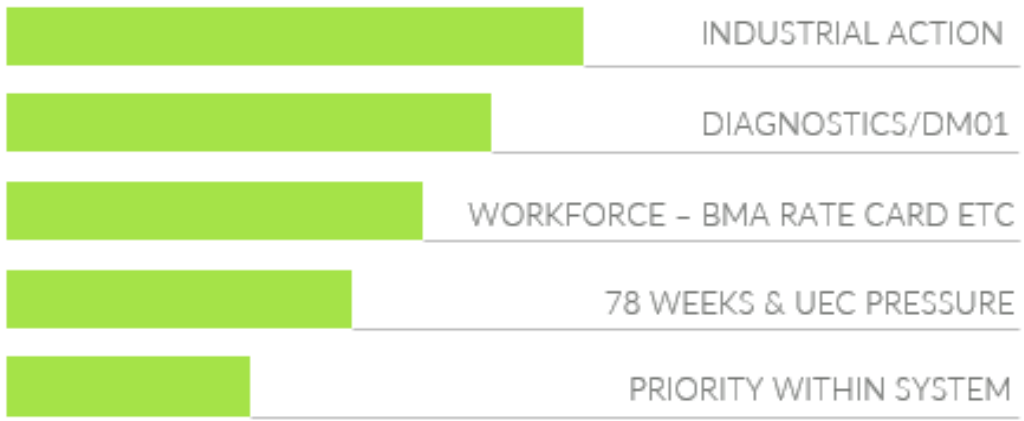
Surgery revised target 371 Weekly average.

Current 6 week average 330

IMPROVEMENT FOCUS



INCREASING SCALE OF CHALLENGE



"It's not the 62 days, it's the 61 nights in between"

patient to Sir Mike Richards 2018

Greater Manchester Cancer

Greater Manchester Cancer

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

GM Cancer Board
27 March 2023

Title of paper:	**Cancer Faster Diagnosis, Operational Improvement, Performance & Recovery**
Purpose of the paper:	To provide an update to the GM Cancer Board on the current operational performance within Cancer, along the current risks, and the actions being taken to mitigate these.
Summary outline of main points / highlights / issues	• Current delivery against the key planning guidance requirements (22/23) • Current performance against the Cancer Waiting Times Standards • Risks and mitigation
Consulted	Main paper N/A Performance information presented to GM SORT and Chief Operating Officers Forum.
Author of paper and contact details	**Name:** Lisa Galligan-Dawson **Title:** Performance Director, GM Cancer **Email:** lisa.galligan-dawson@nhs.net

1. Introduction & Context

This paper provides an overview of the current cancer performance in Greater Manchester (GM), against the national Cancer Waiting Times (CWT) standards, and the key aspects of the 22/23 planning guidance.

The three metrics in the 22/23 system planning return specific to cancer are:

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

The following table details the GM summary of the provider trajectories (including the revised backlog recovery submission, October 22):

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
Revised submission (Oct 22)							2199	2053	1742	1374	1027	668

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

The Cancer Alliance submitted the following trajectory in relation to the CWT standards.

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%			

2. Current Performance – against Planning Guidance 22/23

Backlog Reduction.

The revised trajectory was delivered in November (for the first time) but was not sustained in December. There has been significant improvement in January and February but it is not expected that the end of March planning target (761 and trajectory of 688) will be delivered.

Month Ending / Provider	June 22 Trajectory	03.07.22 (end June final positon)	July 22 Trajectory	31.07.22 (end July final positon)	Aug 22 Trajectory	04.09.22 (End Aug final position)	Sep 22 Trajectory	02.10.22 (End Sep final position)	Revised Oct 22 Trajectory	30.10.22 (End Oct final position)	Revised Nov 22 Trajectory	04.12.22 (End Nov final position)	Revised Dec 22 Trajectory	01.01.23 (End Dec final position)	Revised Jan 23 Trajectory	29.01.23 (End Jan final position)	Revised Feb 23 Trajectory	27.02.23 (End Feb final position)
Bolton	14	34	13	39	13	36	15	32	35	36	32	24	29	19	26	20	23	22
MFT	688	756	589	732	490	746	490	997	827	981	691	869	555	812	385	638	247	375
NCA	500	455	430	532	333	748	222	793	925	749	925	588	749	649	573	588	397	420
Stockport	105	100	100	106	95	103	95	94	90	77	85	80	90	90	85	91	80	97
Tameside &	125	84	112	92	103	150	88	152	150	194	157	142	156	239	155	211	150	159
The Christie	65	81	65	107	65	97	65	86	85	86	85	98	85	92	85	94	85	132
WWL	130	128	110	94	100	112	100	98	87	91	78	97	78	116	65	92	45	65
GM TOTAL	1627	1638	1419	1702	1199	1992	1075	2252	2199	2214	2053	1898	1742	2017	1374	1734	1027	1270

A number of key challenges have recently exacerbated the under performance against this metric.

- Long term sickness / vacancy in Gynaecology and Dermatology at Tameside
- Impact of IT down time at NCA (notable from September 22)
- Impact of HIVE implementation at MFT
- Fragility of Dermatology Services at Salford (NCA)

Faster Diagnosis.

The current position for the FDS standard 63.4% (January 23 latest reported position) against the 75% standard and the 71.52% trajectory.

This compares nationally to 67.0% and 63.7% for NW region.

The performance by provider against the trajectory is:

Faster Diagnosis Standard (target 75%)	Sept. Trajectory	Sept. Actual	Oct. Trajectory	Oct. Actual	Nov. Trajectory	Nov. Actual	Dec. Trajectory	Dec. Actual	Jan. Trajectory	Jan. Actual
GM SYSTEM	13128	10234	14435	11969	13544	14058	12619	11451	14054	12958
	66.54	59.80%	68.25	59.40%	70.40	62.00%	71.74%	64.90%	71.52%	63.40%
Bolton	1376	1596	1388	1534	1380	1642	1422	1382	1387	1355
	85.47	80.10%	84.58	81.60%	76.96	80.10%	81.72%	81.30%	80.39%	77.60%
MFT*	4910	1714	6131	2916	4899	4153	4899	3308	6111	4051
	57.86	49.60%	61.67	61.80%	64.14	65.80%	64.89%	68.70%	65.34%	68.40%
NCA	3258	3252	3110	3656	3258	4167	2962	3531	3110	3940
	62.98	44.70%	66.98	42.20%	70.99	48.50%	74.98%	52.10%	74.98%	52.40%
Stockport	1165	1217	1105	1123	1165	1195	1045	1005	1090	1116
	65.06	62.90%	68.05	67.40%	70.04	62.60%	72.06%	68.50%	72.02%	61.60%
Tameside	1064	1228	1316	1199	1487	1377	1066	1177	1071	1282
	89.66	64.00%	81.84	57.40%	81.84	55.30%	80.02%	57.90%	83.19%	59.40%
Christie	5	5	5	2	5	12	5	6	5	9
	100	40.00%	100	0%	100.00	58.30%	100.00%	33.30%	100.00%	11.10%
WWL	1350	1162	1380	1539	1350	1506	1220	1042	1280	1205
	70.37	81.00%	71.01	69.50%	72.59	74.80%	72.13%	78.70%	72.66%	72.70%

First Treatment volumes

Nationally, treatment volumes are calculated from March 20 to date, and looks to deliver 100% of the expected treatments had the pandemic not struck. At present GM is currently at 93.4% of the expected treatments. This compares to NW 96.4% England average 98%. This places GM the lowest Cancer Alliance. Whilst this is published data, it is acknowledged that falsely low figures have been submitted due to HIVE MFT and the NCA IT outage, which will be corrected at the bi-annual national system refresh.

Nationally, the current month (December 22 is the latest reported month) compared to the same month 2019 is monitored. When undertaking this comparison GM is at

82% (215 treatments below 2019) and the lowest cancer alliance, compared to NW 98.8% and England average 103%.

How much of the shortfall is attributed to data quality and the aforementioned issues is unclear.

3. Cancer Waiting Times Performance.

The latest cancer waiting times performance is detailed below. The breakdown by organisation and tumour site can be found in **Appendix 1**. Of note, although this is the official national reporting. Volume of pathways submitted by MFT remain lower than expected. It is understood that MFT will submit a revised position (this is updated bi-annually by NHSE). It is expected that this will result in deterioration of measures at system level.

Performance by metric by provider and tumour site for the month of January are as follows:

Trust CWT Reporting - National Published Figures

Cancer Standard Performance by Trust

NHS Greater Manchester Integrated Care Board - Performance Across All Standards

Pathway Site: All | Date: January 2023 to January 2023

	Referral to First Seen	Faster Diagnosis	Decision to Treat				Referral to First Treatment		
	Suspected Cancer Patients	All Patients	All First Treatments	Anti-Cancer Drug	Radiotherapy	Surgery	2WW Patients	Consultant Upgrade Patients	Screening Patients
	93.0%	75.0%	96.0%	98.0%	94.0%	94.0%	85.0%	85.0%	90.0%
Grand Total	76.1%	63.4%	87.6%	98.9%	99.0%	86.1%	51.0%	72.4%	77.6%
Bolton NHS Foundation Trust	76.5%	77.6%	90.3%	100.0%		71.4%	84.2%	71.0%	75.0%
Manchester University NHS Foundation Trust	68.7%	68.4%	65.4%	0.0%		56.3%	33.9%	50.7%	95.7%
Northern Care Alliance NHS Foundation Trust	72.3%	52.4%	88.5%	100.0%		100.0%	40.9%	75.9%	0.0%
Stockport NHS Foundation Trust	96.7%	61.6%	94.1%			100.0%	58.3%	87.8%	0.0%
Tameside And Glossop Integrated Care NHS Foundation Trust	76.5%	59.4%	98.0%	100.0%			37.1%	59.3%	0.0%
The Christie NHS Foundation Trust	83.3%	11.1%	96.9%	99.2%	99.0%	99.1%	66.3%	77.5%	77.8%
Wrightington, Wigan And Leigh NHS Foundation Trust	96.9%	72.7%	97.8%	100.0%		90.5%	72.8%	95.5%	76.0%

Trust CWT Reporting - National Published Figures

Cancer Standard Performance by Cancer Site

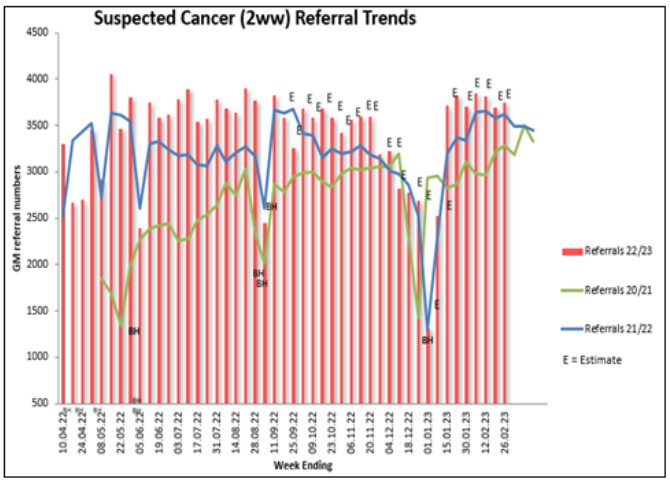
NHS Greater Manchester Integrated Care Board - Performance Across All Standards - by Cancer Site
Date: January 2023 to January 2023

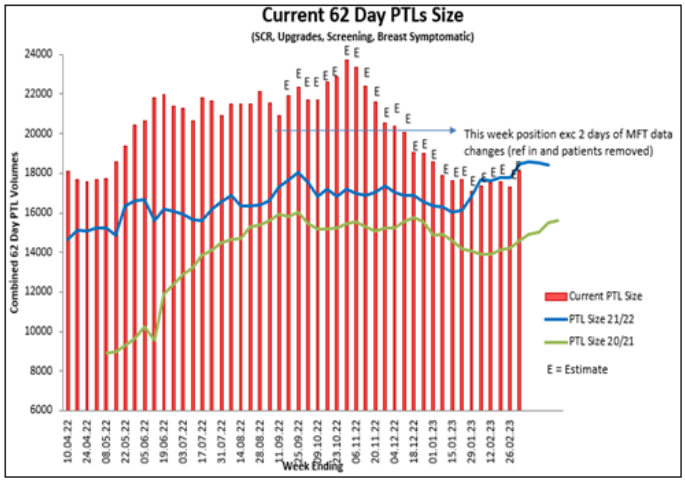
	Referral to First Seen	Faster Diagnosis	Decision to Treat				Referral to First Treatment		
	Suspected Cancer Patients	All Patients	All First Treatments	Anti-Cancer Drug	Radiotherapy	Surgery	2WW Patients	Consultant Upgrade Patients	Screening Patients
	93.0%	75.0%	96.0%	98.0%	94.0%	94.0%	85.0%	85.0%	90.0%
Grand Total	**76.1%**	**63.4%**	**87.6%**	**98.9%**	**99.0%**	**86.1%**	**51.0%**	**72.4%**	**77.6%**
Acute Leukaemia	0.0%	0.0%						50.0%	
Brain/CNS	71.1%	75.7%	100.0%	100.0%	100.0%			100.0%	
Breast	71.3%	90.0%	72.5%	98.5%	100.0%	70.0%	64.4%	71.4%	91.7%
Breast Symptomatic	72.0%	87.6%							
Children's	69.1%	90.3%	100.0%		80.0%		100.0%	100.0%	
Gynaecological	73.2%	44.9%	82.9%	100.0%	97.4%	100.0%	28.6%	76.7%	100.0%
Haematological			98.5%	100.0%	100.0%				
Haematological (Excluding A..	91.4%	68.6%					73.1%	73.9%	100.0%
Head and Neck	82.6%	64.1%	92.3%	100.0%	97.6%	0.0%	25.0%	40.0%	
Lower Gastrointestinal	89.0%	46.7%	90.8%	98.4%	100.0%	92.0%	41.0%	76.7%	27.8%
Lung	89.9%	81.4%	97.4%	90.9%	100.0%	100.0%	53.7%	70.3%	
Other	89.5%	71.4%	100.0%	100.0%	100.0%	66.7%	60.0%	75.0%	
Sarcoma	55.1%	52.9%	94.1%	100.0%	100.0%	100.0%	21.1%	50.0%	
Skin	56.9%	61.0%	66.4%	100.0%	100.0%	95.4%	43.7%	61.3%	
Testicular	94.5%	78.0%					100.0%	100.0%	
Unknown		26.7%							
Upper Gastrointestinal	78.7%	58.9%	91.4%	100.0%	100.0%	90.9%	53.9%	73.7%	
Urological			92.3%	100.0%	98.1%	96.3%			
Urological (Excluding Testicu..	88.2%	56.3%					58.6%	76.8%	

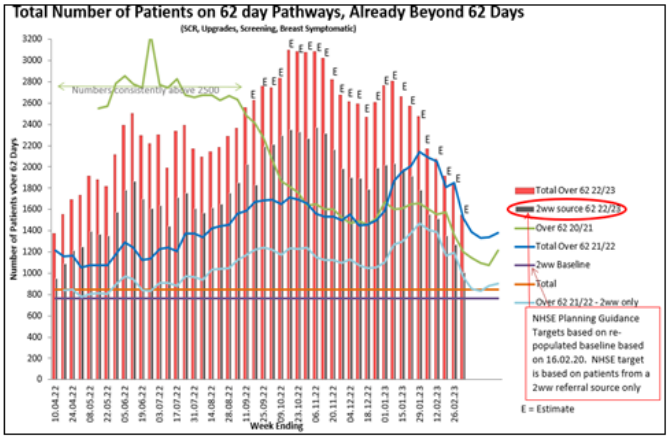
Performance is most significantly impacted by MFT, followed by NCA. It should be noted that there has been ongoing challenges at Tameside linked to skin and gynaecology. It should be noted that both MFT and NCA remain in the national tier one category. Performance in NCA is specifically linked to Skin and Lower GI. MFT performance is evident across most specialities with Urology, Lower GI and Head and Neck the most challenged.

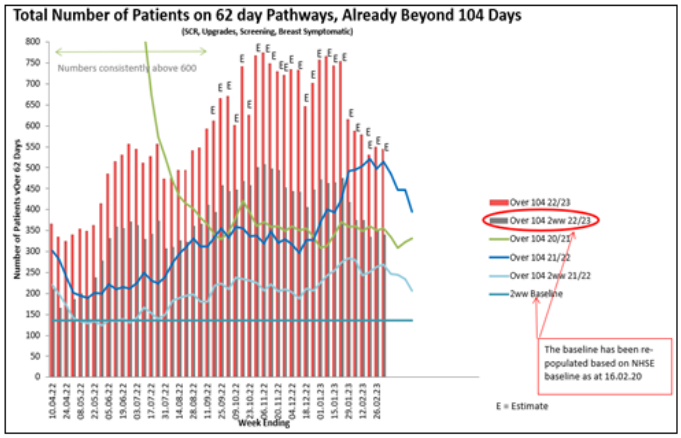
The full performance report including trends by provider and by tumour site across Greater Manchester is included in Appendix 1.

The referral, ptl size and backlog trends can be visualised below, with year on year context.









4. Risks and Mitigation

It is evident that the 22/23 planning objectives will not be met. There are a number of significant areas impacting performance:

- Demand (new referrals) higher than plan
- First line diagnostic wait times not aligned to best practice timed pathways, and significantly elevated in some organisations
- Specialist / staging diagnostic waits longer than the best practice timed pathways
- P2 surgical waiting list elevated and number of patients dated over 28 days is high (>60%)

- Although surgical treatment numbers have increased, delivery of 'first' treatments remains below pre-pandemic levels
- Non-compliance with BPTP across all pathways and Trusts
- Significant challenge in skin and gynaecology pathways
- Time to first attendance and the 'offer' at first attendance (i.e. diagnostics / one stop). Deterioration of 2ww standard (focus shifted to FDS nationally). 2ww delivery important for pathway compliance
- Competing pressures (78 weeks)
- System pressures – covid / NRTR / G&A bed capacity / workforce / demand
- Cancer Management resource and expertise (significant changes and loss of expertise)
- Industrial action / rate card / pensions.

The current mitigating actions being taken are as follows. Further actions and initiatives will be agreed and commenced in line with the 23/24 planning guidance and outlined national priorities. The full work programme and final planning submission will be shared with stakeholders and presented at the next cancer board for assurance:

- Revised trajectory for surgery agreed commenced February 23
- Continued focused work to resolve use of mutual aid lists
- SQD project progressing at pace
- FIT / teledermatology progression. FIT new guidance plan and monitoring commenced.
- Dermatology accelerated actions commenced (albeit behind schedule)
- Recovery panel process in place
- GM level resource review be completed February 23 (Delayed from Dec 22 due to operational pressures) to be shared with COOs March 23.
- CTC pathway improvement initiative commenced across GM

- Cancer Alliance relaunched focussed work on longest waiters with cancer management teams
- Cancer Alliance to re-launch focus on Day 7 and the first 'offer'.
- CDC plans to increase capacity
- BPTP
- Model of care plan for Lung cancer and one stop clinic live and showing continued improvement in median wait to treatment overall and reducing the 'range'. Exploring options to replicate in OG.
- Breast Mastalgia pathway funded and being implemented.
- Consolidation of Oncology Outpatients progressing – first Trust to move April 23 delayed from end March 23 due to operational challenges.

5. Summary and next steps

- Finalised planning and launch of new initaitives to meet the requirements of the 23/24 planning guidance (ICB and Cancer Alliance)
- Revised governance and oversight structure implementation for FDS, Operational Performance and Treatment Variation Programmes

Appendix 1 – Cancer Waiting Times. Reporting January 23 Performance

Trust CWT Reporting - National Published Figures

Performance Over Time

2 Week Wait from Referral to First Seen: Suspected Cancer Patients

NHS Greater Manchester Integrated Care Board | Report Detail: All | Performance Target: 93.0% / 14 Days Standard

The table shows the performance for each locality as the percentage of referrals seen within the standard timeframe. If the target performance is met, it is shown in green. If failed, the performance is shown in red.

n = The Total Count of Patients Seen

	2021 - 2022 FY		2022 - 2023 FY									
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Bolton NHS Foundation Trust	77.5% n=1,281.0	78.5% n=1,523.0	86.3% n=1,157.0	89.0% n=1,438.0	88.1% n=1,381.0	95.0% n=1,363.0	96.0% n=1,571.0	92.6% n=1,424.0	84.8% n=1,335.0	91.4% n=1,391.0	79.3% n=1,169.0	82.4% n=1,167.0
Manchester University NHS Foundation Trust	64.6% n=4,314.0	61.7% n=4,594.0	71.7% n=2,699.0	67.5% n=4,446.0	57.2% n=4,182.0	55.1% n=4,706.0	54.1% n=5,043.0	55.8% n=3,129.0	40.5% n=4,560.0	54.2% n=5,487.0	63.5% n=4,081.0	67.8% n=4,468.0
Northern Care Alliance NHS Foundation Trust	79.4% n=3,369.0	77.1% n=3,757.0	100.0% n=1.0	95.6% n=1,839.0	67.7% n=3,177.0	73.8% n=3,574.0	64.2% n=4,009.0	56.0% n=3,804.0	63.0% n=4,188.0	64.4% n=4,806.0	63.1% n=3,780.0	72.3% n=4,153.0
Stockport NHS Foundation Trust	98.2% n=973.0	98.2% n=1,229.0	94.3% n=1,060.0	96.9% n=1,139.0	93.2% n=1,093.0	96.3% n=1,120.0	98.2% n=1,229.0	98.2% n=1,238.0	98.8% n=1,097.0	99.0% n=1,197.0	97.7% n=1,005.0	96.7% n=1,061.0
Tameside And Glossop Integrated Care NHS Foundation ..	96.4% n=1,201.0	94.6% n=1,395.0	93.5% n=1,202.0	94.5% n=1,338.0	91.5% n=1,241.0	86.1% n=1,291.0	75.4% n=1,383.0	71.7% n=1,288.0	73.8% n=1,250.0	72.4% n=1,219.0	66.6% n=1,241.0	75.6% n=1,283.0
The Christie NHS Foundation Trust	100.0% n=7.0	100.0% n=1.0	100.0% n=3.0	66.7% n=3.0		100.0% n=1.0		100.0% n=4.0		100.0% n=7.0	77.8% n=9.0	83.3% n=6.0
Wrightington, Wigan And Leigh NHS Foundation Trust	97.3% n=1,315.0	93.2% n=1,666.0	93.1% n=1,322.0	95.7% n=1,524.0	92.8% n=1,541.0	93.9% n=1,406.0	90.9% n=1,637.0	82.1% n=1,555.0	93.8% n=1,510.0	97.0% n=1,616.0	98.1% n=1,289.0	96.7% n=1,338.0
ICB Total	79.1% n=12,460.0	77.7% n=14,165.0	84.5% n=7,444.0	84.2% n=11,727.0	74.1% n=12,615.0	74.6% n=13,461.0	70.9% n=14,872.0	69.2% n=12,442.0	64.9% n=13,940.0	69.9% n=15,723.0	71.5% n=12,574.0	76.4% n=13,476.0

Trust CWT Reporting - National Published Figures

Performance Time Series Table by Cancer Site

NHS Greater Manchester Integrated Care Board - 2 Week Wait from Referral to First Seen: Suspected Cancer Patients

93.0% Target - 14 Day Standard

	2021 - 2022 FY		2022 - 2023 FY									
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Grand Total	79.1%	77.7%	84.5%	84.2%	74.1%	74.6%	70.9%	69.2%	64.9%	69.9%	71.5%	76.4%
Acute Leukaemia	100.0%	100.0%			0.0%	100.0%		100.0%	100.0%	100.0%	100.0%	0.0%
Brain/CNS	98.4%	95.2%			93.1%	93.0%	68.8%	51.9%	49.7%	72.3%	92.0%	71.1%
Breast	29.8%	31.6%	47.1%	52.4%	36.8%	34.0%	40.7%	46.1%	42.4%	58.6%	67.1%	71.3%
Children's	91.2%	84.8%	84.6%	91.2%	68.2%	75.4%	68.9%	83.6%	68.4%	58.4%	73.7%	69.1%
Gynaecological	95.7%	95.1%	87.8%	92.9%	89.5%	88.2%	82.1%	72.2%	72.1%	74.9%	74.9%	73.2%
Haematological (Excluding A..	97.9%	93.6%	96.8%	95.3%	96.6%	93.6%	92.0%	96.2%	84.7%	94.2%	85.7%	91.4%
Head and Neck	89.8%	88.1%	80.9%	79.0%	77.7%	73.0%	77.0%	82.2%	77.5%	73.2%	80.9%	82.6%
Lower Gastrointestinal	97.1%	93.4%	95.7%	96.4%	89.1%	93.3%	83.9%	81.1%	86.2%	87.2%	89.8%	89.0%
Lung	98.5%	98.8%	88.7%	94.3%	93.7%	96.3%	98.0%	97.8%	94.2%	95.4%	91.0%	89.9%
Other	98.6%	93.5%	91.3%	95.9%	94.5%	90.7%	92.2%	79.2%	93.5%	78.3%	90.9%	89.5%
Sarcoma	84.0%	56.4%	58.7%	88.0%	78.9%	95.1%	64.9%	91.7%	57.1%	40.9%	55.7%	55.1%
Skin	66.7%	65.1%	95.3%	91.7%	48.9%	53.7%	47.2%	31.0%	28.9%	38.4%	32.4%	56.9%
Testicular	97.2%	96.1%	96.2%	97.8%	96.6%	97.4%	92.7%	94.9%	79.2%	97.9%	100.0%	94.5%
Upper Gastrointestinal	95.7%	96.3%	96.9%	90.8%	92.0%	95.8%	93.9%	89.0%	86.0%	85.5%	77.6%	78.7%
Urological (Excluding Testicu..	94.7%	93.0%	91.6%	92.4%	92.5%	95.0%	90.3%	93.2%	79.3%	84.0%	88.1%	88.2%

Trust CWT Reporting - National Published Figures

Performance Over Time

28 Day Wait from Referral to Faster Diagnosis: All Patients

NHS Greater Manchester Integrated Care Board | Report Detail: All | Performance Target: 75.0% / 28 Days Standard

The table shows the performance for each locality as the percentage of referrals seen within the standard timeframe. If the target performance is met, it is shown in green. If failed, the performance is shown in red.

n = The Total Count of Patients Told Cancer Diagnosis Outcome

	2021 - 2022 FY		2022 - 2023 FY									
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Bolton NHS Foundation Trust	81.5% n=1,423.0	82.3% n=1,767.0	82.2% n=1,304.0	80.2% n=1,624.0	81.2% n=1,525.0	80.8% n=1,539.0	83.8% n=1,694.0	80.1% n=1,596.0	81.6% n=1,534.0	80.1% n=1,642.0	81.3% n=1,382.0	77.6% n=1,355.0
Manchester University NHS Foundation Trust	57.1% n=4,261.0	55.2% n=4,625.0	53.4% n=2,716.0	54.9% n=3,850.0	41.4% n=3,673.0	55.1% n=4,463.0	62.1% n=4,602.0	49.6% n=1,714.0	61.8% n=2,916.0	65.8% n=4,153.0	68.7% n=3,308.0	68.4% n=4,051.0
Northern Care Alliance NHS Foundation Trust	72.3% n=2,929.0	65.9% n=3,506.0		59.5% n=1,231.0	47.0% n=3,297.0	47.8% n=2,925.0	45.2% n=3,365.0	44.7% n=3,252.0	42.2% n=3,656.0	48.5% n=4,167.0	52.1% n=3,531.0	52.4% n=3,940.0
Stockport NHS Foundation Trust	69.2% n=931.0	70.0% n=1,150.0	58.4% n=1,075.0	62.2% n=1,089.0	60.3% n=1,034.0	63.4% n=1,151.0	64.1% n=1,187.0	62.9% n=1,217.0	67.4% n=1,123.0	62.6% n=1,195.0	68.5% n=1,005.0	61.6% n=1,116.0
Tameside And Glossop Integrated Care NHS Foundation ..	83.7% n=1,048.0	80.1% n=1,196.0	77.6% n=1,140.0	78.5% n=1,198.0	76.4% n=1,036.0	77.2% n=1,130.0	76.1% n=1,257.0	64.0% n=1,288.0	57.4% n=1,199.0	55.3% n=1,377.0	57.9% n=1,177.0	59.4% n=1,282.0
The Christie NHS Foundation Trust	100.0% n=7.0	100.0% n=1.0	75.0% n=4.0	75.0% n=4.0		50.0% n=4.0	0.0% n=5.0	40.0% n=5.0	0.0% n=2.0	58.3% n=12.0	33.3% n=6.0	11.1% n=9.0
Wrightington, Wigan And Leigh NHS Foundation Trust	68.1% n=1,363.0	73.6% n=1,548.0	66.2% n=1,299.0	65.3% n=1,526.0	71.2% n=1,397.0	68.8% n=1,283.0	71.6% n=1,408.0	81.0% n=1,162.0	69.5% n=1,539.0	74.8% n=1,506.0	78.7% n=1,042.0	72.7% n=1,205.0
ICB Total	**68.3% n=11,962.0**	**66.9% n=13,793.0**	**65.0% n=7,538.0**	**64.3% n=10,522.0**	**56.2% n=11,962.0**	**60.7% n=12,495.0**	**63.0% n=13,518.0**	**59.8% n=10,234.0**	**59.4% n=11,969.0**	**62.0% n=14,052.0**	**64.9% n=11,451.0**	**63.4% n=12,958.0**

Trust CWT Reporting - National Published Figures

Performance Time Series Table by Cancer Site

NHS Greater Manchester Integrated Care Board - 28 Day Wait from Referral to Faster Diagnosis: All Patients

75.0% Target - 28 Day Standard

	2021 - 2022 FY		2022 - 2023 FY									
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Grand Total	**68.3%**	**66.9%**	**65.0%**	**64.3%**	**56.2%**	**60.7%**	**63.0%**	**59.8%**	**59.4%**	**62.0%**	**64.9%**	**63.4%**
Acute Leukaemia	100.0%	100.0%			100.0%	50.0%	0.0%		66.7%	100.0%	0.0%	0.0%
Brain/CNS	86.9%	77.6%			88.2%	87.7%	83.8%	71.1%	78.3%	78.1%	77.7%	75.7%
Breast	60.7%	64.4%	69.6%	67.8%	46.2%	68.6%	85.4%	89.0%	84.4%	88.4%	91.3%	90.0%
Breast Symptomatic	52.8%	62.5%	62.9%	54.7%	44.5%	58.3%	80.7%	86.7%	77.4%	85.3%	89.1%	87.6%
Children's	98.0%	92.2%	75.0%	95.8%	88.6%	89.2%	86.2%	61.9%	73.1%	63.0%	75.7%	90.3%
Gynaecological	75.6%	70.4%	62.6%	66.7%	67.4%	58.0%	61.6%	55.2%	51.1%	51.6%	52.0%	44.9%
Haematological (Excluding A..	69.9%	72.9%	61.9%	71.2%	68.9%	77.9%	72.3%	77.2%	69.3%	75.7%	68.1%	68.6%
Head and Neck	75.3%	71.9%	66.9%	67.3%	63.2%	57.3%	56.7%	62.7%	62.3%	61.8%	66.5%	64.1%
Lower Gastrointestinal	57.4%	53.1%	48.8%	50.4%	46.7%	53.2%	49.4%	49.6%	50.8%	53.1%	57.7%	46.7%
Lung	80.8%	84.8%	78.7%	77.5%	70.9%	66.2%	64.8%	73.2%	80.8%	82.8%	85.0%	81.4%
Other	70.8%	52.5%	77.3%	66.1%	76.3%	58.7%	83.6%	62.7%	56.1%	66.7%	75.0%	71.4%
Sarcoma	84.6%	62.5%	40.0%	76.5%	56.5%	78.4%	66.7%	70.8%	58.3%	34.1%	45.9%	52.9%
Skin	89.3%	88.0%	88.8%	87.2%	71.4%	62.8%	59.0%	46.3%	39.5%	40.8%	44.2%	61.0%
Testicular	90.0%	90.7%	76.2%	80.6%	75.0%	80.8%	80.0%	80.8%	78.9%	79.6%	67.7%	78.0%
Unknown	44.2%	41.9%	42.9%	53.2%	51.3%	44.8%	45.0%	43.8%	45.5%	39.1%	0.0%	26.7%
Upper Gastrointestinal	65.0%	62.6%	59.2%	55.6%	49.1%	62.6%	56.1%	58.4%	56.0%	61.5%	65.9%	58.9%
Urological (Excluding Testicu..	72.0%	66.6%	67.8%	65.2%	59.3%	65.1%	64.0%	59.7%	65.4%	59.9%	58.3%	56.3%

Trust CWT Reporting - National Published Figures

Performance Over Time

62 Day Wait from Referral To First Treatment: 2WW Patients

NHS Greater Manchester Integrated Care Board | Report Detail: All | Performance Target: 85.0% / 62 Days Standard

The table shows the performance for each locality as the percentage of referrals seen within the standard timeframe. If the target performance is met, it is shown in green. If failed, the performance is shown in red.

n = The Total Count of Patients Receiving Treatment

	2021 - 2022 FY		2022 - 2023 FY									
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Bolton NHS Foundation Trust	80.5% n=59.0	81.7% n=84.5	85.4% n=61.5	85.8% n=95.0	80.7% n=70.0	83.0% n=76.5	80.4% n=89.5	79.1% n=67.0	83.2% n=89.5	80.8% n=83.5	81.6% n=62.5	84.2% n=69.5
Manchester University NHS Foundation Trust	44.9% n=199.5	55.4% n=219.5	48.4% n=155.0	31.4% n=169.0	40.4% n=201.5	43.8% n=203.0	44.4% n=199.5	31.6% n=136.0	29.6% n=79.5	37.6% n=131.5	44.2% n=121.0	33.9% n=166.5
Northern Care Alliance NHS Foundation Trust	63.1% n=150.5	65.3% n=147.0	20.5% n=44.0	31.8% n=88.0	44.7% n=159.0	47.1% n=163.5	48.1% n=154.0	42.6% n=171.5	40.1% n=151.0	44.7% n=206.0	51.6% n=168.5	40.9% n=181.0
Stockport NHS Foundation Trust	70.2% n=62.0	79.3% n=55.5	85.1% n=43.5	52.1% n=60.5	59.3% n=61.5	60.6% n=77.5	68.4% n=58.5	69.7% n=59.5	65.7% n=68.5	74.5% n=74.5	75.6% n=63.5	58.3% n=66.0
Tameside And Glossop Integrated Care NHS Foundation ..	83.7% n=49.0	77.0% n=50.0	86.9% n=42.0	73.9% n=55.5	58.1% n=37.0	58.2% n=39.5	66.7% n=37.5	60.0% n=55.0	59.8% n=46.0	59.8% n=43.5	58.7% n=37.5	37.1% n=44.5
The Christie NHS Foundation Trust	75.8% n=47.5	80.7% n=70.0	80.3% n=78.5	72.3% n=70.5	77.4% n=68.5	86.6% n=59.5	72.1% n=61.0	72.9% n=70.0	78.3% n=53.0	81.7% n=87.5	77.9% n=65.5	66.3% n=84.5
Wrightington, Wigan And Leigh NHS Foundation Trust	66.1% n=57.5	71.9% n=64.0	68.8% n=78.5	77.6% n=80.5	75.5% n=77.5	71.5% n=79.0	70.2% n=80.5	73.3% n=50.5	75.0% n=80.0	76.7% n=75.0	76.0% n=60.5	72.8% n=57.0
ICB Total	**62.5% n=625.0**	**68.3% n=690.5**	**65.0% n=503.0**	**56.3% n=619.0**	**56.1% n=675.0**	**58.3% n=698.5**	**58.8% n=680.5**	**54.4% n=609.5**	**58.6% n=567.5**	**59.8% n=701.5**	**61.9% n=579.0**	**51.0% n=669.0**

Trust CWT Reporting - National Published Figures

Performance Time Series Table by Cancer Site

NHS Greater Manchester Integrated Care Board - 62 Day Wait from Referral To First Treatment: 2WW Patients

85.0% Target - 62 Day Standard

	2021 - 2022 FY		2022 - 2023 FY									
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Grand Total	**62.5%**	**68.3%**	**65.0%**	**56.3%**	**56.1%**	**58.3%**	**58.8%**	**54.4%**	**58.6%**	**59.8%**	**61.9%**	**51.0%**
Acute Leukaemia	100.0%				66.7%	100.0%	100.0%	100.0%		100.0%	100.0%	
Brain/CNS	100.0%	50.0%	0.0%	0.0%		50.0%		100.0%	33.3%		100.0%	
Breast	54.0%	71.2%	73.8%	55.1%	59.6%	62.5%	58.7%	63.9%	63.9%	63.7%	74.8%	64.4%
Children's	0.0%					100.0%						100.0%
Gynaecological	42.9%	52.0%	56.9%	51.5%	31.7%	42.2%	45.9%	39.7%	63.0%	49.3%	42.4%	28.6%
Haematological (Excluding A..	58.1%	71.0%	66.0%	42.6%	58.5%	70.0%	61.2%	53.8%	74.2%	70.6%	63.3%	73.1%
Head and Neck	35.7%	36.6%	40.0%	30.0%	38.1%	27.0%	39.5%	47.3%	41.1%	50.0%	56.1%	25.0%
Lower Gastrointestinal	60.2%	52.6%	61.5%	44.9%	39.7%	50.0%	44.1%	47.1%	38.2%	50.6%	50.4%	41.0%
Lung	59.8%	75.9%	55.9%	48.8%	52.3%	46.3%	53.4%	55.8%	43.4%	60.3%	56.3%	53.7%
Other	66.7%	25.0%	62.5%	50.0%	83.3%	83.3%	40.0%	100.0%	50.0%	28.6%	100.0%	60.0%
Sarcoma	0.0%	45.5%	20.0%	15.4%	0.0%	60.0%	42.9%	30.0%	0.0%	46.2%	0.0%	21.1%
Skin	80.0%	83.9%	74.4%	68.1%	67.8%	75.1%	75.8%	54.5%	64.4%	48.3%	49.4%	43.7%
Testicular	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Upper Gastrointestinal	62.5%	62.8%	47.9%	55.0%	54.1%	56.7%	56.2%	55.1%	52.1%	46.6%	60.6%	53.9%
Urological (Excluding Testicu..	64.4%	77.0%	77.6%	68.3%	63.7%	59.1%	63.9%	55.4%	70.8%	73.4%	73.1%	58.6%

Trust CWT Reporting - National Published Figures

Performance Over Time

31 Day Wait from Decision To Treat to All First Treatments

NHS Greater Manchester Integrated Care Board | Report Detail: All | Performance Target: 96.0% / 31 Days Standard

The table shows the performance for each locality as the percentage of referrals seen within the standard timeframe. If the target performance is met, it is shown in green. If failed, the performance is shown in red.

n = The Total Count of Patients Receiving Treatment

	2021 - 2022 FY		2022 - 2023 FY									
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Bolton NHS Foundation Trust	97.1% n=105.0	98.6% n=138.0	98.9% n=93.0	99.3% n=144.0	99.1% n=107.0	100.0% n=129.0	97.9% n=146.0	99.1% n=115.0	99.3% n=150.0	97.8% n=138.0	97.4% n=115.0	90.3% n=103.0
Manchester University NHS Foundation Trust	86.9% n=405.0	91.1% n=392.0	87.2% n=282.0	84.0% n=332.0	84.9% n=378.0	86.2% n=377.0	85.2% n=357.0	80.8% n=198.0	78.2% n=147.0	87.7% n=203.0	80.4% n=153.0	65.4% n=266.0
Northern Care Alliance NHS Foundation Trust	98.7% n=235.0	97.4% n=231.0	100.0% n=3.0	90.6% n=96.0	94.2% n=225.0	96.6% n=237.0	96.5% n=254.0	88.6% n=236.0	90.6% n=245.0	94.6% n=276.0	96.9% n=262.0	88.5% n=253.0
Stockport NHS Foundation Trust	94.6% n=92.0	97.7% n=86.0	97.3% n=73.0	94.2% n=86.0	95.8% n=96.0	96.5% n=114.0	95.3% n=85.0	94.6% n=93.0	96.5% n=113.0	99.1% n=116.0	96.4% n=83.0	94.1% n=102.0
Tameside And Glossop Integrated Care NHS Foundation ..	100.0% n=52.0	98.4% n=62.0	100.0% n=49.0	98.4% n=61.0	100.0% n=42.0	100.0% n=48.0	100.0% n=50.0	98.6% n=69.0	100.0% n=52.0	100.0% n=50.0	100.0% n=42.0	98.0% n=49.0
The Christie NHS Foundation Trust	98.1% n=321.0	96.7% n=330.0	97.8% n=323.0	97.7% n=345.0	98.5% n=335.0	98.6% n=354.0	98.7% n=379.0	97.9% n=338.0	97.5% n=314.0	97.0% n=361.0	98.2% n=327.0	96.9% n=355.0
Wrightington, Wigan And Leigh NHS Foundation Trust	99.1% n=117.0	99.0% n=98.0	97.2% n=109.0	97.5% n=119.0	97.0% n=99.0	97.3% n=113.0	95.1% n=122.0	96.6% n=88.0	99.2% n=132.0	98.1% n=108.0	98.9% n=94.0	97.8% n=90.0
ICB Total	94.6% n=1,327.0	95.7% n=1,337.0	94.7% n=932.0	93.2% n=1,183.0	93.5% n=1,282.0	94.8% n=1,372.0	94.3% n=1,393.0	92.8% n=1,137.0	94.0% n=1,153.0	95.4% n=1,252.0	95.3% n=1,076.0	87.6% n=1,218.0

Trust CWT Reporting - National Published Figures

Performance Time Series Table by Cancer Site

NHS Greater Manchester Integrated Care Board - 31 Day Wait from Decision To Treat to All First Treatments

96.0% Target - 31 Day Standard

	2021 - 2022 FY		2022 - 2023 FY									
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Grand Total	94.6%	95.7%	94.7%	93.2%	93.5%	94.8%	94.3%	92.8%	94.0%	95.4%	95.3%	87.6%
Brain/CNS	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast	88.2%	98.0%	95.6%	93.1%	91.6%	91.6%	90.8%	91.6%	90.4%	92.5%	87.9%	72.5%
Children's	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%
Gynaecological	98.4%	95.9%	94.1%	98.5%	89.5%	95.0%	94.7%	96.6%	96.2%	93.8%	88.0%	82.9%
Haematological	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	100.0%	100.0%	100.0%	100.0%	98.5%
Head and Neck	95.9%	90.3%	88.2%	84.9%	93.2%	94.4%	93.2%	90.2%	93.0%	100.0%	100.0%	92.3%
Lower Gastrointestinal	93.5%	92.6%	91.8%	88.7%	91.0%	94.1%	94.1%	95.3%	92.3%	94.8%	97.9%	90.8%
Lung	97.5%	98.6%	98.3%	97.6%	94.4%	94.1%	93.9%	98.4%	96.8%	98.2%	98.1%	97.4%
Other	94.4%	100.0%	94.4%	81.8%	100.0%	100.0%	95.5%	100.0%	100.0%	94.4%	100.0%	100.0%
Sarcoma	92.3%	81.8%	100.0%	100.0%	100.0%	100.0%	80.0%	83.3%	100.0%	100.0%	100.0%	94.1%
Skin	92.2%	94.0%	92.5%	84.8%	87.1%	92.4%	92.6%	82.2%	91.3%	90.0%	90.1%	66.4%
Upper Gastrointestinal	96.8%	92.5%	90.1%	98.0%	98.1%	97.3%	96.6%	94.3%	99.1%	96.7%	98.9%	91.4%
Urological	95.9%	96.0%	95.2%	93.6%	96.5%	96.1%	96.7%	92.0%	91.8%	95.6%	96.6%	92.3%

Early Cancer Diagnosis

Ali Jones
Director of Commissioning
& Early Diagnosis
27th March 2023

Highlights / Update – Early Diagnosis

Early Diagnosis plans for 2023-24 submitted to the National Cancer Programme 7th March

Clinical Decision Support Tool **'THINK CANCER'** – full roll out by 31/3/2023 with positive feedback from practices on the impact of this tool

Joint programme of **primary care education** commissioned from Gateway C for 2023-24 – webinars continuing (February & March 2023 FIT, Prostate, Cancer in the Homeless)

PCN engagement event– 7th March 80+ attendees – outputs will inform the detail of our primary care engagement for 2023-24

Launch of a programme of work on **innovation in early diagnosis and cancer care** for 2023-24 supported by Cancer Alliance funding

Significant improvement in the % of lower GI referrals sent with **FIT** result included – 22.1% April 2022 to 62.5% January 2023

Roll out plans for **Targeted Lung Health Check** Programme in GM submitted to the national team – work progressing at pace on the operational delivery

Appointment to the Strategic Lead for Cancer role in '10GM' to formalise VCSE engagement with the GM Cancer Alliance

GM Cancer Alliance **Health Inequalities Programme Board** – new clinical lead appointed; strategy refreshed and to be presented to Cancer Board in May 2023

Manchester Cancer

Cancer Alliance Delivery Plan Template 2023/24
Part 1 – Narrative Plans & Milestones

Contents (ctrl + click to skip to section)

Notes on how to use this template

There are two parts of the delivery plan template, which together make up your delivery plan for 2023/24:

PART ONE This Word template: for Narrative Plans and Milestones

PART TWO An Excel template: for Finance Allocations, Success Measures and Risk Register

- These delivery templates should be completed together, referencing the deliverables covered in the Cancer Alliance Planning Pack 23/24 which can be found on the Futures Workspace here.
- Following review by the national team and assurance of plans by Regions, this delivery plan will form the basis of your Cancer Alliance funding agreement for 23/24.
- Progress against this plan will then need to be submitted in-year using the Cancer Alliance quarterly reporting template.

PART ONE - Cancer Alliance Delivery Plan Template

Please ensure that all narrative plans;

- are written with direct reference to the information set out in the detailed deliverable slides in the Planning Pack,
- explain how the allocated funds from your SDF (per the amounts set out in the finance tab of Part two) will be used,
- reference any activities to address health inequalities,
- where specified, set out key milestones across the four quarters of the year, and
- can be appropriately resourced within reasonable timeframes which do not back load activity into Q4. Plans outlined in this template will need to be delivered within your indicative funding allocation by the end of March 2024.

Plans should also incorporate relevant components of system plans, and for Alliances which straddle more than one local system these templates should support bringing a number of local plans together into a single whole.

How to use this template:

- You can navigate through the document by referencing the contents table above, pressing 'ctrl' on the keyboard at the same time as right-clicking on the section you want to skip to or using the 'navigation pane' view by selecting it in the view tab above.
- Please ensure you fill out **all peach spaces** on this form before returning it (unless it is a targeted programme that your Cancer Alliance is not running, in which case mark as N/A).
- Please note that the text boxes will expand as you type, you do not need to fit your narrative into the size you see in the blank template.

PART TWO – Finance Allocations, Success Measures and Risk Register – how to use

- Instructions on how to use this can be found on the 'guidance tab' of the part two template.

Process & timeline

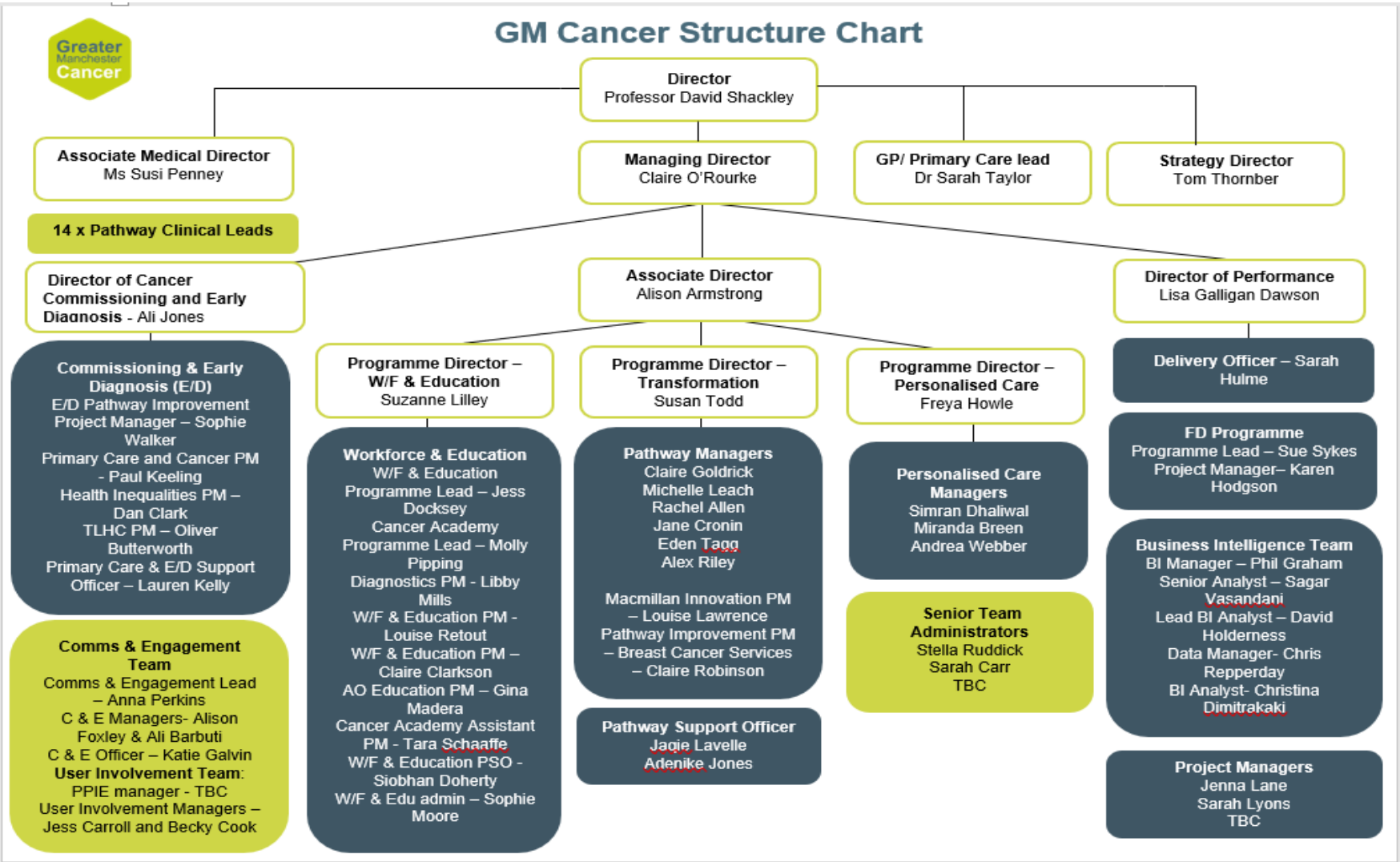
Action	Timing
Release of 23/24 Planning Guidance	23 Dec 2022
Guidance and templates to support operational plans at an ICS level released. Templates cover activity, finance, workforce and general narrative.	13 Jan 2023
Cancer Alliances 23/24 Planning Pack and templates are released to Workspace	**27 Jan 2023**
First draft ICS trajectories and high-level narratives submitted	23 Feb 2023*
First draft Cancer Alliance delivery plan submitted *(NB. submissions should be complete as feedback from the national team will be by-exception)*	**7 March 2023**
National review of and feedback on Cancer Alliance plans to Regions	23 March 2023
Final ICS trajectories and narratives submitted	30 March 2023*
Final Cancer Alliance delivery plans submitted	**18 April 2023**
Expected issue of funding agreements (pending Regional assurance of final plans)	May (TBC)

**Timelines for ICS submissions are set by NHSE Ops Planning colleagues*

Cancer Alliance Key Information

Name of Cancer Alliance: Greater Manchester Cancer Alliance

Key contact name & email: Claire O'Rourke & Alison Armstrong (alison.armstrong7@nhs.net)



Cancer Alliance Delivery Plan 22/23

1 Workstream: Faster Diagnosis and Operational Performance

1.1 Operational Performance

Deliverable	Work with systems and providers to develop and implement action plans to improve Cancer Waiting Times performance with a focus on achieving the Faster Diagnosis Standard (FDS) and reducing the number of the longest waiting patients on cancer pathways waiting more than 62 days
Success measures	• Number of patients waiting longer than 62 days following an Urgent Suspected Cancer referral (against system plans) • Faster Diagnosis Standard Performance (against system plans)

Name and email of Cancer Alliance Lead Contact: Lisa Galligan-Dawson. lisa.galligan-dawson@nhs.net

Narrative plan for 23/24

GM Cancer Alliance is committed to improving the FDS compliance rate and reducing the volume of patients over 62 days on an active pathway. An FDS Programme Board, replacing the RDC Programme Board, and encompassing Site specific and NSS pathways will hold its first meeting with representation from provider Trusts, primary care, clinical pathway boards in April 23. The Cancer Alliance has a newly appointed Associate Medical Director with the portfolio of FDS, Operational Delivery, Pathway Innovation, and Inequalities to strengthen the clinical focus on pathway delivery due to commence in post Q1 23/24.

The work programme will be under pinned with a new Cancer operational delivery policy and systemwide action plan. This approach has been agreed through the GM Cancer Board. Plans are expected to be signed off and ratified in March / April to allow implementation and monitoring from Q1. These will focus on generic pathway aspects, including diagnostics, histopathology and pathway management standards and a systemwide re-focus on the first attendance offer and timeframe.

Pathway specific aspects of FDS will focus on BPTP milestones where these are defined (see BPTP section).

In relation to FDS – the four most challenged pathways for FDS performance across GM are Lower GI, Skin, Gynaecology and Urology and will be the top priority for intervention, with LGI and Skin being the highest volume. Both Skin and Gynaecology are listed within the sustainable

services work programme in GM given the challenges also faced in the delivery of Elective services. In terms of the over 62 day backlog – the same specialities contain the highest volumes across GM.

Lower GI – High level actions include

Full implementation of FIT – resulting in improved FDS, reduced endoscopy activity (improving waiting times for those needing endoscopy), reduced referrals into the LGI pathway. Including targeted intervention in any patient cohorts not using FIT to its full potential

Improved CT an MR access via Trust CDC plans

CTC pathway re-design and single queue across GM – including variation in waiting times between organisations

Mutual aid treatment initiative

Skin – High level actions include

Full roll out of tele-dermatology across GM – improving FDS, reducing secondary care demand.

Focussed work programme on Seborrheic Keratosis & Actinic Keratosis (including education, training, advice and guidance) with the aim of reducing demand

Explore new roles in skin cancer delivery in conjunction with the workforce team and skin clinical pathway board.

Gynaecology – High level actions include

Review of the endometrial cancer sub speciality pathway and one stop PMB provision

Review of TVUSS and Hysteroscopy workforce and pathway interdependency (non cancer, maternity)

PET single queue

Diagnostic bundle and CDC provision

Urology – High level actions include

MR capacity improvement via CDC

TULA roll out

TURBT pathway re-design and ‘Hub’ creation

Improvement workstreams will be pathway focussed spanning all providers, and include sharing good practice. Specific attention and intervention will be initiated in tier 1 and 2 organisations, and those with the greatest variation.

Although the above pathways are the worst performing against FDS and have the highest volume of patients in the over 62 day backlog, it is recognised that there are other pathways that require improvement – both in terms of clinical pathway (OG, Lung etc) and performance (H&N, Lung, OG, Breast) etc. This narrative does not include all actions and interventions in the wider work programme that will encompass all key pathways, building on the work undertaken in 22/23 including the innovative breast mastalgia pathway and the lung one stop treatment clinic, including roll out to a second tumour site. However, once this is approved, this can be shared.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables - e.g. clinical protocol finalised, new staff appointed, lease for mobile imaging capacity signed etc)

Q1	Project Manager commences in post Systemwide Cancer Operational Policy and GM wide action plan to be ratified and implemented (work to be completed Q1, Q2, Q3) Lunch of FD & OP priorities to GM Cancer Clinical Pathway Boards, and Trust Clinical Cancer Leads Commence workstream to improve waiting times for pathway critical reflex testing Speciality work programmes to commence 'Focus fortnight' – First offer / Day 7 initiative
Q2	CTC pathway change initiative implementation to commence TULA improved uptake roll out plan to commence TURBT Hub proposal to be agreed Seborrheic Keratosis & Actinic Keratosis pathway to be agreed and launched First unit live with mastalgia pathway
Q3	TURBT hub in operation Roll out of second one stop treatment clinic model
Q4	Continuation of above actions GM Wide Improvement initiative 'focus fortnight'

1.2 Faster Diagnosis – Best Practice Timed Pathways (BPTP)

Deliverable	Deliver BPTP milestones in suspected prostate, lower GI, skin and breast cancer pathways:

	• Provide support to providers to embed BPTP milestones, with a focus on those performing below the England FDS average and/or with significant 62d+ backlogs in priority pathways • Provide intensive support to tier 1 & 2 providers to support improvement of performance against priority cancer pathways
Success measures	• % of urgent cancer referrals for suspected prostate cancers meeting all timed pathway milestones • % of urgent cancer referrals for suspected colorectal cancers meeting all timed pathway milestones • % of urgent cancer referrals for suspected breast cancer and breast symptomatic where cancer is not initially suspected meeting FDS • % of urgent cancer referrals for suspected skin cancer meeting FDS • % of suspected skin cancer managed through teledermatology pathways (2 week audit at end of Q1 and Q3)

Name and email of Cancer Alliance Lead Contact: Lisa Galligan-Dawson. lisa.galligan-dawson@nhs.net and Sue Sykes. susansykes@nhs.net

Narrative plan for 23/24
(Cancer Alliances should set out specific plans for each provider for pathway improvements and particular elements that are to be funded)

GM Cancer are committed to delivering the BPTP milestones, and in particular the focus on time to treatment MDT.

The current 'gap' in delivery is variable between the pathways, and each provider Trust. A number of pathway specific actions are detailed, which will be tailored to each organisation and their individual pathway challenges. Intense support will be provided to tier 1 and 2 trusts, and those where performance deteriorates during the course of the year.

A number of underpinning work programmes will be delivered via the clinical pathway boards, including MDT and patient protocolisation, clinical guidance, diagnostic bundle guidance, clinical step-down policies and supportive audits.

Skin: The GM Cancer Alliance have a Skin Pathway Board in place who work with the Alliance FDS lead on the design and implementation of pathways to deliver improvements in CWT standards including the Best Practice Timed Pathway. Given the pressure on dermatology services in GM, this work now aligns closely with the GM Dermatology Transformation Board – a system wide improvement board reporting into the GM Elective Recovery & Reform Board. Given the system approach that's being taken to this specialty, the Cancer Alliance will have clinical and officer members of the transformation board to ensure the planning guidance requirements for Cancer Alliances are included in the work programme of this board. There are very close working relationships with the PCNs in Greater Manchester and strong primary care clinical leadership of the dermatology transformation programme.

The key actions to drive compliance with BPTP are listed in the FDS and OD section. In summary they focus on tele-dermatology roll out, demand management and workforce.

Prostate: There is a clinical pathway board for urology which will support pathway improvement in conjunction with the FDS & OD team. The key challenge in delivery of the prostate BPTP is access to MRI and the waiting times for IP biopsy. The focussed work will include:

Driving increases in MR capacity through CDC, insourcing, outsourcing and increasing core capacity

Driving the use of TULA to release theatre capacity that can be re-purposed for the wider urology improvement work

Focus on time to triage, and the first offer

SLA treatment clinic activity improvement workstream (to reduce variation)

LGI: There is a clinical pathway board in place for Lower GI, which now has a Clinical Lead (2PA) and a Deputy Lead (1PA) due to start in the coming month. This additional investment in clinical leadership will support pathway improvement and development. The key challenge in deliver of the BPTP varies between organisation but triage, consistent access to timely endoscopy, and histopathology are amongst the most significant. It is expected that FIT will support reduced demand into the LGI pathway and better use of the limited endoscopy resource. Additional focussed work will include:

CTC pathway re-design, and single GM queue

Sustainability of increased access to endoscopy in conjunction with the Endoscopy Network

Improved pathway links between endoscopy and imaging, reducing waiting times and variation

Mutual aid for surgical treatment delivery

FIT negative patient pathway management protocol compliance

Breast: GM Cancer has a high functioning clinical pathway board for Breast. Within the work delivered is an innovative mastalgia (breast pain) pathway. This pathway design is now coming into fruition with recruitment underway and the first unit expected to go live in Q2. This programme of work is expected to significantly reduce demand in the symptomatic pathway, thus freeing resource to support the 2ww triple assessment. There is also a focussed programme of work under PSFU, which, when delivered is expected to release clinical time to be re-directed within the 2ww pathway. Breast is under the sustainable services workstream in GM, given the significant workforce issues, particularly in Breast Radiology. In addition, the following will be a focus:

Explore capacity requirements and benefits of under 40s and males under 50's clinics.

Patient level feedback initiative to primary care to improve referral quality and reduce in appropriate referrals. EUR review against cosmetic procedures to release capacity

Workforce initiatives looking at new roles, additional roles and greater capacity.

Focus on first offer and Day 7

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables - e.g., Recruitment of patient tracker for colorectal pathway by May 2023; 12 weekly ringfenced mpMRI slots embedded for the prostate pathway in X NHS Trust by Dec 2023)

Q1	Skin: Agree definition of tele-dermatology for GM; Engagement in preparation for Q1 audit Skin: Launch SOP for one stop services and direct listing Skin: Agree education and pathway re-design work for Seborrheic Keratosis & Actinic Keratosis LGI: Launch pathway standard for radiology following endoscopy LGI: Launch and audit compliance against FIT negative patient pathway management LGI: Agree CTC pathway and resource requirements LGI: Agree mutual aid model Prostate: Assessment of additional capacity via CDC and further gap analysis Prostate: Commence wider urology work programmes designed to contribute to the overall release of capacity (theatre space / beds) Prostate: Triage and Day 7 work programme to commence – in line with focus fortnight Breast: Scope new clinic offers, resources required, and benefits expected Breast: Triage and Day 7 work programme to commence – in line with focus fortnight
Q2	Skin: Completion of Q1 audit LGI: Commence implementation of new GM wide CTC pathway LGI: Audit FIT compliance and FIT negative pathway management compliance – reporting through pathway board, primary care cell, GM endoscopy network and across GM to benchmark Prostate: Commence SLA consolidation work programme Breast: First unit launch of mastalgia pathway
Q3	Skin: Hold GM wide dermatology training event for PCNs / GPs; prepare for Q3 audit To be determined by Q1 and 2 progress
Q4	Skin: Completion of Q3 audit To be determined by Q1 and Q2 progress

1.3 Faster Diagnosis – Non-Specific Symptoms (NSS) pathways

Deliverable	• Deliver 100% population coverage for Non-Specific Symptoms (NSS) pathways • Ensure sustainable commissioning arrangements for NSS pathways are in place for 2024/25
Success measures	Number of people referred on to a NSS pathway *NB. please ensure that the trajectories you submit in Part 2 for this measure, are aligned with the trajectories produced by your constituent ICBs under the national planning guidance*

Name and email of Cancer Alliance Lead Contact: Sue Sykes. susansykes@nhs.net

Narrative plan for 23/24

Since April 2022, the NSS pathway can be accessed by every GP practice in each of the 10 localities across GM, providing 100% population coverage. Work will continue in 2023/24 to support engagement with primary care to identify those areas where referrals are lower and where further information and education is required to improve the awareness of NSS pathways and increase GP referrals. The other primary focus in 23/24 will be on the sustainability of the NSS pathway.

In 2023/24 we will continue to support providers in collaboration with the GM Cancer Pathway Boards in the development of the re-direct process established at the NCA site. Particular focus on those pathways, where vague symptoms are most common and those pathways that are most challenged in meeting the FDS. The NSS teams will also be monitoring the impact of the new FIT guidance on the NSS service.

Over the course of the last year the alliance programme team has facilitated providers in supporting the national FD evaluation and taken part in various evaluation exercises, case studies and piloting of materials. The evaluation materials to date are shared and at the same time we are gathering local evaluation materials. Both local and national evaluation evidence, qualitative and quantitative will form part of the business case for sustainability of the pathway from 2024/25.

Through the work of the GM NSS Finance and Sustainability task and finish group we will continue to monitor baseline data and NSS activity to inform the future sustainability and long- term commissioning arrangements for the NSS pathway and services. Providers of NSS services are represented on this group, along with locality representation. Development of sustainability business cases will be a priority for the alliance programme team in Q1 of 2023/34, with the aim of being in a position to present sustainability plans during Q2.

The alliance FD programme will ensure there is ongoing alignment and collaboration with the GM Early Diagnosis programme and the GM CDC programme, as outlined in the 23/24 operational planning guidance. Ensuring early identification, workforce and diagnostic capacity is in place to support NSS referral demand and optimise the diagnostic element of existing cancer pathways.

Working with the GM Cancer Health Inequalities lead and the BI team the NSS programme will carry out an analysis of patient access to NSS pathway services by ethnicity, gender, post codes and areas of known deprivation, to establish uptake and understand where targeted engagement and awareness raising needs to take place, to improve uptake of the NSS services where required.

The funding will be used to sustain the additionality the current service provision throughout 2023/24.

Planned milestones

(Please include short narrative descriptions of milestones that relate to deliverables - e.g. New NSS services at X hospital to launch in October 2023; Business case for all NSS pathways across the Cancer Alliance to be drafted by July 2023)

Q1	Sustainability business case for all NSS services to be drafted by the end of Q1 Review of NSS data quality to be complete by the end of April 2023 Assess impact of new FIT guidance on NSS services by the end of Q1 Continue to progress the roll out of re-direct process with challenged pathways, where symptoms align to NSS symptoms
Q2	Sustainability case to be presented to key stakeholders Increase referrals from low up take area
Q3	Continued monitoring of referral rates, conversion rates and pathway waiting times
Q4	As Q3

2 Workstream: Early Diagnosis

2.1 Timely Presentation

Deliverable	• Set out Timely Presentation objectives, with a particular focus on the most deprived 20% • Establish metrics to measure achievement of objectives and review tracking regularly
Success measures	Cancer Alliances should set own metrics to measure achievement of Timely Presentation objectives

Name and email of Cancer Alliance Lead Contact: Anna Perkins / Ali Jones - alison.jones8@nhs.net

Narrative plan for 23/24
(Narrative plan should include an overview of activities being undertaken to ensure local objectives are met, and that target audiences and local stakeholders/partners are engaged)

The Cancer Alliance Communications and Engagement Team will continue to have a heavy focus on supporting timely presentation from the public. They will continue support specific projects such as the prostate cancer targeted case finding project, sun safety (skin pathway), NHS-Galleri and Targeted Lung Health Checks in addition to supporting other symptom awareness for key pathways such as lower GI and barriers to access. They will develop supporting communications campaigns and consider health inequalities as part of this approach – for example via targeted advertising linked to deprivation data, producing communications in a variety of formats including alternative languages, suitable for learning disability audiences and considering appropriate messages appropriate to cultural barriers. They will work with local teams to ensure that communications are suitable to the specific needs of local communities. A plan to support the three national cancer screening programmes has also been developed and this will be delivered alongside symptomatic campaigns.

The Cancer Alliance Early Diagnosis team will continue engagement with the 14 tumour-site-specific Pathway Boards to support the development of public facing messages and events in relation to timely presentation

In addition to the GM design and delivery of local and national patient/public facing messages, the Cancer Alliance will provide funding to the 10 localities (formerly CCGs) to deliver messages to specific communities in their areas – funding will support the production of materials and provide a resource for engagement activities.

The Cancer Alliance will commission our VCSE sector to appoint a VCSE strategic lead (Cancer & Inequalities), a role which will be vital to the strategic engagement of the VCSE sector channelling insights into the challenges faced by a broad range of marginalised communities into decisions taken at a GM level. Our comms team with support from this role to ensure we are gathering local intelligence and spreading our messages to the commutes that we need to speak to most. We will use our VCSE small grants programme to amplify that message in targeted communities where needed.

The cancer alliance will use, and commission where needed, data and insights to inform our communication campaigns and initiatives focussing on timely presentations.

The Cancer Alliance will commission a series of Talk Cancer training sessions from CRUK to increase the skill, knowledge and ability of those in primary care (including but not limited to General Practice) and our community and VCSE sector, to have cancer conversations supporting the community to spot the signs and symptoms of cancer and present in a timely manner to primary care.

All timely presentation activity including the work ours comms and engagement team do will be monitored to ensure we a reaching and engaging people from our most deprived communities and other communities that are deemed needed through the data and insight work.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	Launch of the mobile van and associated communications campaign for the targeted prostate cancer case finding project Development of communications campaigns for sun safety, bowel screening and bowel cancer awareness Continuation of BAU communications activities on symptom awareness – bowel focus Design of VCSE small grants programme Design and commence community Talk Cancer training programme Appointment of VCSE strategic lead (Cancer & Inequalities)	
Q2	Continuation of BAU communications activities on symptom awareness Sun Safety event launches (July) - skin First round of small grants applications Continuation of Talk Cancer training programme	
Q3	Continuation of BAU communications activities on symptom awareness – specific focus on lung, breast Second round of small grants applications Continuation of Talk Cancer training programme	
Q4	Continuation of BAU communications activities on symptom awareness – specific focus on cervical World Cancer Day awareness activities (Feb) Third round of small grants applications Continuation of Talk Cancer training programme	

2.2 Primary care pathways – PCN DES

Deliverable	Cancer Alliances should outline a clear set of actions and milestones to support PCN DES delivery
Success measures	National Team will work with the national diagnostics team on the development and prioritisation of metrics. This will not require input from Cancer Alliances

Name and email of Cancer Alliance Lead Contact: Paul Keeling/Ali Jones- alison.jones8@nhs.net

Narrative plan for 23/24

We have developed an extensive programme of support for colleagues in primary care during 2022-23 which we will continue to developed in 2023-24, including:

Continue the development of the CDS Tool across all GP practices, informed by pathway boards and requests from colleagues in primary care. This will include all assets developed and refreshed 2ww suspected cancer referral forms.

Support targeting and prioritisation of efforts based on identified need across all primary care providers with improved data content, quality and utility.

Provide planning support packs, that include reference to targeting those with identified needs, to all PCNs to assist in the delivery of early diagnosis efforts and with particular reference to the requirements of the DES.

Support the GM Primary Care Clinical Lead and 10 Locality Clinical Leads as essential members of the network of posts supporting early diagnosis across general practice.

Recruit 5 Primary Care Early Diagnosis Facilitators to support PCNs and general practice to identify, plan and execute activities in support of the early diagnosis ambition which includes prioritising activities to address inequalities.

Continue to resource and work with the identified Cancer Leads in all PCNs to ensure PCNs and general practice make best use of the range of assets available and the network of support to deliver their plans in support of early diagnosis.

Engage and support community pharmacy and dental colleagues in the early diagnosis of cancer with their patient cohorts.

All Primary Care Pathway and PCN DES activity will be targeted to where the need is greatest. All projects will have a complete equality impact assessment to assess and mitigate any risk associated with health inequality groups. We will monitor all projects uptake, outcomes and delivery

against the PCN DES against deprivation and any other health inequality group as identified through the EIA, local intelligence and the Core20Plus5 framework.

Our primary care facilitators (PCFs) will be key to identifying, targeting and supporting practice and PCNs in the areas of most need. The PCFs will work to ensure tools, resources, innovations in pathways, training and education are targeted to and taken up by identified practices and PCNs, this will be monitored and reported.

The GM Cancer Alliance will continue commissioning GatewayC education for Primary Care professionals with the aim of improving the recognition of cancer symptoms and confidence in using Suspected Cancer Referral forms for all pathways. £175,000 will be allocated to the production of GatewayC webinars with expert speakers, and subsequent Fast Facts videos and A4 Infographics. There will also be 3 in-person "Cancer Forum" events which bring together secondary care Clinical Leads and GPs, allowing all members the opportunity to engage with whole pathways and discuss referral practice.

The Cancer Alliance will continue engagement with PCNs to determine the topics of these webinars and events as well as being responsible for promoting them and disseminating resources following these sessions.

We will identify specific topics during the year requiring additional / intensive education and will work with colleagues to deliver these.

The 'Cancer Academy' in GM will support and deliver education to colleagues in primary care to enhance/complement the programme commissioned from Gateway C.

Note: planned milestones are not required for this deliverable.

2.3 Primary care pathways – GP Direct Access

Deliverable	Cancer Alliances should use their contacts and links across secondary and primary care to support Regional Diagnostics Leads implement GP Direct Access (GPDA) guidance, and feed into the development of regional action plans
Success measures	National Team will work with the national diagnostics team on the development and prioritisation of metrics. This will not require input from Cancer Alliances

Name and email of Cancer Alliance Lead Contact: Dr Sarah Taylor – sltaylor@nhs.net

Narrative plan for 23/24

The Cancer Alliance Clinical Lead for Primary Care is working with GM and NW teams to scope current provision for GP direct access diagnostics and ensure future requirements from a cancer pathway perspective are considered in the development of GM plans.

The work will involve working with CDH leads and NSS clinics and will consider access for / requests from all primary care professionals (ensuring appropriate IRMER regulations are adhered to).

This plan has been shared with and signed off by the GM diagnostic leads before submission by the Cancer Alliance

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	Scope current provision Promoting the use of NSS pathways by primary care Ongoing involvement and engagement by the Cancer Alliance in GM/NW diagnostic lead meetings	
Q2	Consider access to specific pathway in GM e.g. CT in lung pathway Ongoing involvement and engagement by the Cancer Alliance in GM/NW diagnostic lead meetings	
Q3	Design and deliver training for non-medical referrers Ongoing involvement and engagement by the Cancer Alliance in GM/NW diagnostic lead meetings	
Q4	Expand access to investigations in additional pathways Ongoing involvement and engagement by the Cancer Alliance in GM/NW diagnostic lead meetings	

2.4 Prostate cancer case finding projects

Deliverable	Cancer Alliances running prostate cancer case finding projects should ensure these are delivered according to local plans
Success measures	• Number of prostate cancers found in prostate case finding projects • Stage of prostate cancers found in prostate case finding projects

Name and email of Cancer Alliance Lead Contact: Ali Jones - alison.jones8@nhs.net

Narrative plan for 23/24

An analysis of the cohort most at risk has been undertaken using GP system data. The eligible patients have been identified in each practice and will be contacted as per the practice's capacity. Practices have been contacting their eligible patients with a Prostate Cancer UK developed "Risk Checker", encouraging them to book an appointment with their GP for a PSA counselling conversation. The Cancer Alliance will monitor the volume of patients contacted, and subsequent PSA testing referrals.

The Greater Manchester Cancer Alliance chose the delivery model of a mobile van in areas convenient to the target population. The locations of the mobile van are identified by working with VCSE representatives from Jewish charities, Caribbean and African charities and health support networks, as well as patient ethnicity and family history data on GP practice systems. The locations correlate to the areas of highest deprivation in Greater Manchester. The mobile van will be active from the 3rd of April 2023- 29th August 2023 and be situated in each location for a minimum of 3 working days. The eligible population will be aware of the van's location through a SMS prompt from their GP and a media campaign featuring notable Afro-Caribbean community leaders and local celebrities encouraging presentation at the van.

The Prostate Case-finding Task and Finish group consists of clinical leadership from the strong input of a GP, Urology Consultants, a Cancer Lead Nurse, as well as knowledge of the target population from representatives of Afro-Caribbean VCSE organisations and a GM Cancer Communications Lead, which has enabled the production of a Communications Strategy involving the public, GP patients and Primary and Secondary Care. This group is currently agreeing on the Clinical Pathway for patients attending the mobile van and will be further supported by a Project Manager recruited for this project, starting on 6th March 2023. Our next steps are to finalize the appointment booking system for patients and continue working with the National Evaluation Commissioning Support Unit and our in-house Business Intelligence team to approve a dataset collected on the van.

As part of the prostate cancer case finding project an equality impact assessment will be complete to assess the potential risk to health inequalities groups and add any risks and action to their project plan. The project will monitor the engagement and uptake of the prostate risk

checker and take up of PSA testing by men over 45 who are black or have a family history of prostate cancer, with a focus on ensuring equity of access from the most deprived areas of GM.

The Cancer Alliance will develop targeted communications and engagement initiatives in partnership with our community and VCSE sector to ensure take up form this targeted group.

Note: planned milestones are not required for this deliverable.

2.5 Pharmacy pilots

Deliverable	Cancer Alliances running pharmacy pilots should ensure these are delivered according to local plans
Success measures	• Number of community pharmacy consultations resulting cancers found • Stage of cancers found through community pharmacy pilots

Name and email of Cancer Alliance Lead Contact: Paul Keeling/Ali Jones - alison.jones8@nhs.net

Narrative plan for 23/24

The aim is to begin the pilot in Q1 2023/24 across two localities in GM (Stockport and Bolton). Community Pharmacists (CPs) in both localities have been identified and the requirements for CPs to deliver the pilot are being progressed. GM's Community Pharmacy Provider Company (CHL) will be supporting the implementation and delivery of the pilot with the allocation of a dedicated resource. CHL will report into the GM steering group established to provide oversight of the pilot.

Representatives from primary and secondary care have been included in the membership of the steering group which has assisted in ensuring the referral pathways being utilised by the pilot will be supported.

Note: planned milestones are not required for this deliverable.

2.6 Targeted Lung Health Checks

Deliverable	Cancer Alliances to deliver: • Invitation, Lung Health Check (LHC) attendance and CT scan run rates in line with expansion plans agreed with the National team • Uptake of LHCs above 50% • A clear plan for further expansion in 2024/5
Success measures	• Number of first invitations sent to eligible participants • Number of Lung Health Checks completed • Uptake (%) of Lung Health Checks • Number of CT scans completed (baseline and follow-up combined)

Name and email of Cancer Alliance Lead Contact: Oliver Butterworth/Ali Jones - alison.jones8@nhs.net

Narrative plan for 23/24
(Please incorporate expansion plans for 2023/4 including expected eligible population coverage by year end; Alliance staffing plans for TLHC delivery and data and financial management plans for local project delivery)

Expansion Plans

At present, there are active projects in Tameside & Glossop, Salford and Manchester (North). These projects are brought together under the governance of the Greater Manchester (GM) Targeted Lung Health (TLHC) Programme Board. This board is co-chaired by the Medical Director of the Cancer Alliance and the NHS GM ICB Chief Officer for Population Health & Inequalities. The board oversees the delivery of existing projects and provides strategic oversight to expansion across the GM Cancer Alliance footprint.

The board approved a risk-stratified, PCN-level rollout for TLHCs across GM, using a fleet of mobile clinics and scanners. This approach used data pertaining to socioeconomic deprivation, smoking prevalence, and lung cancer incidence & mortality to determine the order in which participants would be invited into the programme; this ensures that health inequalities are reduced in a systematic way. This decision was ratified by the GM ICS Joint Planning & Delivery committee.

Expected Population Coverage

It is expected that approximately 20 – 22 % of all people aged 55 – 74 years old will have been invited for a lung health check by March 2023. The Cancer Alliance has developed plans to invite the eligible population by March 2027 however these are dependent on having the necessary CT, diagnostic, and treatment capacity to safely manage all patients within the statutory waiting times. Based on the most recent trajectories, 35,805 first invitations will be sent in 23/24. Population coverage % TBC early Q1 as plans are developed.

The Salford and Manchester (North) projects will invite participants who have since aged-in to the programme and non-responders to initial invitation however it is unclear as to how this activity contributes to population coverage.

Programme & Financial Management

The GM Cancer Alliance recruited a TLHC project manager in 2022/23 to support the Director of Early Diagnosis & Commissioning with the delivery of this programme of work. Trajectory planning is coordinated by the TLHC project manager and is completed in conjunction with provider organisations, taking into consideration the impact that TLHC activity has on specialised diagnostic and treatment services.

There will be cancer alliance representation at all necessary NHSE meetings and the project manager will meet with their NHSE TLHC account manager on a quarterly basis to discuss progress against key deliverables/milestones. Quality Assurance and MI submissions will be coordinated by the TLHC project manager to ensure timely returns with any potential delays being escalated to the national team. The Cancer Alliance will provide targeted communications and engagement initiatives to increase uptake of TLHCs in low uptake groups as the programme expands.

Quarterly finance and activity meetings will be held with TLHC providers to ensure that activity targets are being met and that correct allocations are transferred from NHSE. Any anticipated underspend will be communicated to the national team to prevent misallocation of resources. Governance processes are already in place to agree how to use capital funding awards in GM with links to the regional imaging networks

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	Commence reinviting Salford non-responders/newly eligible participants, conclude Tameside baseline scanning, quarterly assurance meeting with providers
Q2	Commence reinviting Manchester non-responders/newly eligible participants, quarterly assurance meeting with providers
Q3	Operationalise 2nd CT scanner, commence invitations for GM TLHC Programme expansion cohort 1, quarterly assurance meeting with providers
Q4	Send 35k first invitations, complete trajectory setting exercise for 24/25 in line with available assets/capacity, quarterly assurance meeting with providers

2.7 Faecal Immunochemical Testing (FIT)

Deliverable	• Established pathway in place in primary care to limit referrals in those with FIT <10ug and no other concerning symptoms, in line with BSG/ACPGBI guidance

	• Established protocol in secondary care for patients referred on the Lower GI FDS pathway with FIT <10ug, FBC and normal examination, either to be discharged back to their GP or rerouted onto an alternative pathway • 80% of LGI urgent referrals accompanied by a FIT result • <20% of colonoscopies performed on the LGI FDS pathway do not have an accompanying FIT result • Minimise the number of colonoscopies performed on patients with FIT<10ug
Success measures	• CAN-01: Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result *NB. please ensure that the trajectories you submit in Part 2 for this measure, are aligned with the trajectories produced by your constituent ICBs under the national planning guidance* • Percentage of LGI FDS referrals that at clinical triage fall into the following FIT bandings: <10 ug/gm; 10 – 100 ug/gm; >100ug/gm; No FIT available; FIT not appropriate • Percentage of colonoscopies performed on the LGI FDS pathway relative to FIT bandings: <10 ug/gm; 10 – 100 ug/gm; >100ug/gm; No FIT available; FIT not appropriate

Name and email of Cancer Alliance Lead Contact: Ali Jones - alison.jones8@nhs.net

Narrative plan for 23/24
(Cancer Alliances are asked to include detail on supporting systems to fully adopt BSG/ACPGBI guidance and to remove FIT negative patients with no concerning symptoms from the LGI FDS pathway)

GM Cancer Alliance produced a primary care pathway for Lower GI / FIT in 2022-23 which is in line with BSG/ACPGBI guidance and provided a range of primary care information and education resources throughout Q3 and Q4 2022-23. Secondary care guidance was developed and signed off by the Cancer Alliance Colorectal Pathway Board before circulation to all NHS Trusts in GM.

A FIT negative pathway has been approved and shared with secondary care along with standardised GP communications re referrals received without FIT results.

The Cancer Alliance will continue to operation a FIT Task & Finish group in 2023-24 with representation from primary care, Trust Cancer Managers and pathology departments. This group has patient representation.

The FIT Implementation team will complete and equality impact assessment to assess the potential risk to health inequalities groups and add any risks and action to their project plan. As part of FIT implementation GM Cancer Alliance will produce a suite of accessible information to support all patients to be confident in its use. The programme will monitor uptake of FIT pre referral by groups as identified through the EIA process and act accordingly to ensure equity of use. The programme will also undertake an audit to assess the impact on delays in the pathway pre referral from the introduction of FIT, with particular focus on how this impacts different health inequality groups.

The Cancer Alliance have created a section of the Tableau system to present GM wide CAN-01 IIF figures at a locality and PCN level – this will support our PCNs and localities to identify areas where improvement is required.

Funding will be allocated to continue FIT Co-ordinator roles in secondary care in 2023-24

The Alliance will continue to gather data from secondary care providers against the thresholds included in the planning template for referrals received with / without a FIT result attached and details of colonoscopies undertaken

The Alliance continue to participate in GM Endoscopy Network meetings where issues relating to FIT will be raised when required / appropriate.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables e.g. LGI FDS referral pathways updated in primary care to align with BSG/ACPGBI guidance by May 2023, pathway developed in secondary care for those with FIT <10, FBC and normal examination to enable discharge/referral to alternative pathway by June 2023)

Q1	Pathways approved for primary care and secondary care in 2022-23: Cancer Alliance to monitor ongoing use of these pathways Referral form revised in 2022-23 to reflect BSG guidance – use of the form will be audited and practices NOT using this form identified for additional support/education Gateway C / GM Cancer event with FIT and Lower GI pathways on the agenda – audience is PCN Cancer Leads / Primary Care Completion of EIA	
Q2	Review of IIF data on a monthly basis and actions identified at GM and locality level Ongoing sharing of education information for primary care to support adherence to BSG guidance and GM pathways	
Q3	Review of IIF data on a monthly basis and actions identified at GM and locality level Audit to investigate delays in the pathways pre referral	
Q4	Review of IIF data on a monthly basis and actions identified at GM and locality level	

2.8 Colon Capsule Endoscopy (CCE)

Deliverable	• Maintain or improve CCE run rates for symptomatic services • Maximise data uploads to the evaluation
Success measures	• Number of CCE case reports uploaded to the eCRF for inclusion in the evaluation • Average number of capsules swallowed p/site p/week.

Name and email of Cancer Alliance Lead Contact: Sophie Walker/Ali Jones - alison.jones8@nhs.net

Narrative plan for 23/24
(Cancer Alliances are asked to provide detail on how they plan to maintain or improve CCE run rates, maximise consent rates and evaluation uploads, and address any outliers in relation to completion and onward referral rates)

The cancer alliance will liaise with pilot sites to establish a target delivery rate for 2023/24 and continue to work with pilot sites to ensure completion of management information returns on a monthly basis. We will continue to address any barriers to delivery and rectify those as required. We will work with pilot sites to address any barriers to eCRF completion.

The cancer alliance will investigate the potential for continuation of CCE as BAU at the pilot sites, and work on the development of a business case if required. There are strong relationships from a commissioning perspective between the alliance and NHS GM IC which will facilitate this process.

As part of the programme of work, an equality impact assessment will be complete to assess the potential risk to health inequalities groups and add any risks and action to their project plan. As part of CCE implementation GM Cancer Alliance will produce a suite of accessible information to support all patients to be confident in its use. The programme will monitor uptake and completion of CCE by groups as identified through the EIA process and act accordingly to ensure equity of use.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	Confirm run rates for 2023-24 Complete EIA
Q2	Produce patient information to support patients throughout the CCE preparation and procedure
Q3	Improve eCRF completion at pilot sites to at least national average (54% at present)

Q4	Development and system consideration of business case for sustainability beyond 31/3/2024 using evidence packs and guidance from the NHS Cancer Programme

2.9 Lynch syndrome

Deliverable	All colorectal and endometrial cancers should be tested for Lynch syndrome
Success measures	• Percentage of colorectal tumours receiving initial tumour testing for Lynch syndrome • Percentage of endometrial tumours receiving initial tumour testing for Lynch syndrome *(Sample audit – see Cancer Alliance role in Cancer Alliance Planning Pack).*

Name and email of Cancer Alliance Lead Contact: Sophie Walker/Ali Jones - alison.jones8@nhs.net

Narrative plan for 23/24
(Cancer Alliances should include plans to work with Lynch Champions to conduct a snapshot audit, or if an audit has been completed provide details on what this showed and what plans will be put in place to address areas of concern)

Lynch champions have been identified in each colorectal and endometrial MDTs. Audits have been completed for all endometrial MDTs and almost all colorectal MDTs. The audits show that MMR testing is performed in 90% of new endometrial diagnoses, and in only 60% of new colorectal diagnoses. Training webinars, online modules and education events are shared by the alliance with the pathology workforce network, colorectal pathway board members, gynaecology pathway board members, and colorectal and gynae CNSs to ensure clinicians are aware of training support available to them.

The 2-hub model has been developed following discussions with clinicians and pathologists to identify and overcome barriers in Lynch syndrome testing. This model is currently being implemented, which will enable MMR testing to be embedded in the colorectal and endometrial pathways. The cancer alliance will work with the pathology network to provide education around Lynch syndrome and the 2-hub model.

Once the hubs have been in use for a number of months, the cancer alliance will re-audit the centres to assess the percentages of colorectal and endometrial tumours receiving Lynch syndrome testing.

As part of the programme of work, an equality impact assessment will be complete to assess the potential risk to health inequalities groups and add any risks and action to their project plan.

As part of the re audit the centre will report on differences in testing of health inequalities groups as identified by the EIA, ensuring any findings built into the improvement plans.

Our health inequality lead will work with the local genomic and family history pathways to ensure that the progress that is made with lynch testing supports the alliance’s ambition to reduce inequalities in cancer care.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	2 hub pathology labs ready to start receiving samples from across GM following recruitment of biomedical scientists at each hub
Q2	Develop SOP to support delivery of 2-hub model and distribute across providers and pathology
Q3	Re-audit centres to assess improvement in MMR testing, including differences in testing of health inequalities groups as identified by the EIA
Q4	Determine and implement any improvements/changes dependent on audit results

2.10 Liver – Surveillance

Deliverable	Cancer Alliances to support Liver Services to invite >80% of patients with cirrhosis to 6-monthly ultrasound surveillance, support >60% of those invited to attend
Success measures	• Number of people identified as at high risk of liver cancer (with cirrhosis/advanced fibrosis) • Number of people invited to six monthly liver ultrasound surveillance (within the last six months) • Number of people who have attended liver ultrasound surveillance (within the last six months)

Name and email of Cancer Alliance Lead Contact: Sophie Walker/Ali Jones - alison.jones8@nhs.net

Narrative plan for 23/24

The cancer alliance will identify key contacts in Trusts to form a project working group which will meet regularly to identify the biggest challenges in liver surveillance delivery and implement improvements in liver surveillance pathway. Through this group, the cancer alliance will establish whether providers are consistently inviting high risk patients to surveillance appointments. This will also include work with GM and local population health teams as well as the community and VCSE sector to identify and support those cirrhosis/advanced fibrosis patients, working in partnership with organisation such as local drug and alcohol services and secure estates to ensure all parts of the pathway are considered.

We will work with BI colleagues to collate data on patients at high risk of liver cancer and attendance at liver surveillance appointments and perform ongoing reviews of the data to ensure improvements have been made to the pathway. We will work with providers and the ICB to ensure sufficient ultrasound capacity is commissioned to handle the increase in patients invited and attending their liver surveillance appointments. We will also support providers to establish systems and processes to increase the number of eligible patients invited for surveillance. Support will also be available to offer peer support and/or pathway navigators to improve attendance at surveillance appointments.

As part of the programme of work, an equality impact assessment will be completed to assess the potential risk to health inequalities groups and add any risks and action to their project plan. The programme will monitor the uptake of Liver Surveillance by groups as identified through the EIA process and act accordingly to ensure equity of uptake.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	Establish project working group with representatives from providers and population health Collect baseline liver surveillance data (as per success measures)
Q2	Completion of Equality Impact Assessment
Q3	Develop patient communications to improve attendance at liver surveillance appointments

Q4	Audit of liver surveillance invitations and appointments attended

2.11 Liver – Case Finding

Deliverable	To pilot blood tests/fibroscans for those at high risk of fibrosis/cirrhosis, identified through a search of primary care data, and refer for liver surveillance
Success measures	No specific measures will be set by the national team as all procurement and delivery of this is to be completed nationally

Name and email of Cancer Alliance Lead Contact: Sophie Walker / Ali Jones - alison.jones8@nhs.net

Narrative plan for 23/24
(As this work will be largely nationally led, a detailed Cancer Alliance plan is not required, however we would be grateful for an early indication of any PCN areas Cancer Alliances know may be interested in participating in this project)

The Cancer Alliance will liaise with PCN Cancer Leads in Q1 2023-24 to establish interest in engagement in this project. We will also support the national team by sharing practices on primary care data searching, to see if this will inform the liver case finding project.

Note: planned milestones are not required for this deliverable.

2.12 Cytosponge

Deliverable	Maintain delivery of Cytosponge in secondary care, support the evaluation, and agree an onward strategy for transition into BAU commissioning
Success measures	Total number of Cytosponges delivered

Name and email of Cancer Alliance Lead Contact: Sophie Walker / Ali Jones - alison.jones8@nhs.net

Narrative plan for 23/24
(If your plans differ significantly to 2022/23, please explain why)

The cancer alliance will liaise with pilot sites to establish a target delivery rate for 2023/24 and continue to work with pilot sites to ensure completion of management information returns on a quarterly basis. We will explore the possibility of additional pilot sites with those providers that have the capacity and capability to set up and deliver the service. We will also work with BI colleagues to perform a regional evaluation, which will form part of the BAU discussions and development of a business case if required. The OG Pathway Board will receive regular updates on the progression of this project and will assist in addressing any issues with delivery. The Pathway Board will also support the production of proposals for BAU commissioning.

As part of the programme of work, completion of an equality impact assessment will be considered to assess the potential risk to health inequalities groups and add any risks and action to the project plan. The programme will seek to monitor the use of Cytosponge by groups as identified through the EIA process and act accordingly to ensure equity of use. As part of the evaluation the process, consideration of the impacts of access to Cytosponge by deprivation and other health inequality groups will be assessed and any finding will be built into the BAU discussions and plans.

Note: planned milestones are not required for this deliverable.

2.13 Pancreatic cancer (inherited high risk)

Deliverable	All Cancer Alliances to establish a process to identify and triage patients who meet NG85 criteria to the Regional pancreatic cancer surveillance coordinator for assessment and enrolment into the EUROPAC study
Success measures	None. National team will seek to secure collection of number of enrolments and other KPIs into contract with EUROPAC

Name and email of Cancer Alliance Lead Contact: Sophie Walker / Ali Jones- alison.jones8@nhs.net

Narrative plan for 23/24

The cancer alliance will hold internal discussions with the HPB Pathway Board clinical lead and pathway manager to establish the process to triage eligible patients (commenced Q4 2022-23 on receipt of planning guidance for 2023-24).

We will also establish a relationship with regional surveillance coordinator once appointed through regular meetings.

This project has been allocated to a member of the alliance early diagnosis team to provide the necessary co-ordination at an alliance level

Note: planned milestones are not required for this deliverable.

2.14 Local Innovation

Deliverable	Identify, fund, support and share learnings from local innovations and projects **with a particular focus on early diagnosis**
Success measures	No specific measures will be set by the national team. Alliances should set own metrics for projects

Name and email of Cancer Alliance Lead Contact: Ali Jones- alison.jones8@nhs.net / Alison Armstrong – alison.armstrong7@nhs.net

Narrative plan for 23/24

GM Cancer Alliance Digital & Innovation Board will lead a programme of work across the Alliance to identify (and subsequently ensure these are designed/delivered) innovation in Cancer pathways - this will include all Alliance programmes - Faster Diagnosis & Operational Performance; Early Diagnosis / Primary Care / GM localities; Personalised Care; Cross cutting Alliance work programmes (e.g. Education & Workforce; Inequalities; Comms & Engagement). Process to be developed with clear criteria in line with NHS Cancer Programme planning guidance for innovation in 2023-24

This approach will include an increased focus on connecting the work of the Cancer Alliance Early Diagnosis Programme Board with the leads in early cancer diagnosis research programmes.

Artificial Intelligence (AI) pilot in lung chest X-Ray in progress and will be concluded and evaluated in Q3.

Identification of additional AI pilots to be considered and undertaken where these may benefit areas of particular workforce challenges

Single Queue Diagnostic Programme continues and will reach evaluation and case for change in Q3.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	GM Cancer Alliance Digital & Innovation Board to release criteria for funding and produce programme of innovation projects for 2023-24 in line with Cancer Alliance planning guidance – supported by financial allocation Pathway Boards to undertake assessment of tumour site views early in Q1 to identify projects for funding Outputs from Cancer Alliance Clinical Leads session February 2023 to inform a programme of innovation work in early diagnosis and pathways
Q2	Ongoing delivery and review of programme of work developed to support this arm of the Alliance plans in 2023-24
Q3	Ongoing delivery and review of programme of work developed to support this arm of the Alliance plans in 2023-24
Q4	Ongoing delivery and review of programme of work developed to support this arm of the Alliance plans in 2023-24

2.15 GRAIL

Deliverable	A. For Alliances participating in clinical trial: Support retention & onward referral of patients in the NHS-Galleri Clinical trial B. For Alliances NOT participating in the clinical trial: • Establish and test the clinical and operational processes for the GRAIL Interim Implementation Pilot • Commission the local biosampling service for the GRAIL Interim Implementation Pilot
Success measures	No specific measures will be set by the national team, activities can be reported as part of the narrative section in quarterly returns

Name and email of Cancer Alliance Lead Contact (if applicable): Sophie Walker/Alison Armstrong – alison.armstrong7@nhs.net

Narrative plan for 23/24
No plan is required at this stage. However, once requirements for the delivery of Galleri testing from April 2024 have been finalised, a planning exercise related to this programme will be completed.

3 Workstream: Treatment and Care

3.1 Treatment variation – GIRFT implementation

Deliverable	Alliances to continue to oversee the implementation of 3 selected treatment recommendations from the national lung Getting It Right First Time (GIRFT) report.
Success measures	Link to all 13 lung GIRFT metrics here, please note Alliances are only to report against the 3 metrics which they have already selected in 22/23

Name and email of Cancer Alliance Lead Contact: Lisa Galligan-Dawson. lisa.galligan-dawson@nhs.net

Narrative plan for 23/24
Cancer Alliances should provide an overview of implementation plans for **each** individual recommendation, and where appropriate, plans to improve data reporting and collation for the corresponding metric.

GM Cancer Alliance has proactively worked on the GIRFT recommendations for Lung, with strong clinical leadership.

The top three recommendations chosen for focus were.

No 9. *All trusts should have an overall radical treatment rate of 85% or more in those patients with NSCLC stages I-II and of performance status 0-2. This includes all treatment modalities (surgery, radiotherapy including SABR, multimodality treatment and thermoablative techniques).* GM cancer implemented a regional one-stop lung cancer clinic for patients suitable for curative intent treatment but deemed at higher risk (joint clinic includes surgeons, anaesthetists, clinical oncologists, oncogeriatrics, tobacco dependency practitioners, prehab4cancer). This is our key intervention to ensure optimal access to curative intent treatment in early stage disease. The clinic evaluation will be completed in 23/24 to assess impact and scalability. GM is also developing an investment proposal for an expansion of the thermoablative service to ensure regional & equitable access with appropriate infrastructure to deliver.

No15. *Trusts should record and monitor multimodality treatment in stage IIIA disease and offer radical intent treatment as standard in fit patients.* engagement. Above actions further support this objective. The evaluation of the One Stop Clinic model may lead to a proposal for a regional mStage 3 service expanded to include medical oncology.

No 14. *Trusts should monitor rates of post-surgical adjuvant and neoadjuvant treatments and this data should be available for national benchmarking*. The surgical and oncology teams have completed a detailed audit of adjuvant rates in 2021 with an understanding of reasons behind not proceeding to adjuvant chemotherapy. A prehab-prehab-rehab service through the prehab4cancer programme has been developed and launched and will support patients with prehab immediately from discharge after surgery in preparation for adjuvant chemo. This will be delivered and evaluated in 23/24. GM also has a business case to develop a post resection MDT to review all pathological staging, peri-

operative events and review optimal adjuvant treatment as well as record adjuvant rates for benchmarking. Adjuvant treatment is rapidly changing and needs a workforce to deliver prolonged courses of adjuvant immunotherapy and TKI therapy. GM is developing a business case to expand the adjuvant team to deliver this workload and deliver novel pathways likely adjuvant treatment at home. This will be a multi-million pound investment. A Heath Economics case will be developed looking at ROI over a 3 and 5 year period.

The 23/24 work programme will build on the work that commenced in 23/24 with funding to support the ongoing delivery of the pre-hab expansion and the one stop clinic and the evaluation of both services to include impact on delivery against these objectives, improvements in standards of care, health economics and pathway delivery.

GM will continue to optimise data locally but requires support from NHSE to obtain row level data from COSD data feeds (GM offered to be a pilot site for onboarding) and has provided a formal request to add an additional data request in the national lung cancer audit.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables - e.g. on boarding an analyst to support the work, access to data set up)

Q1	Plan onboarding of row level data with NHSE and NHSE Digital subject to approval Design evaluation of pre-hab expansion and lung one stop clinic Complete health economics business case for adjuvant treatment and for the expansion of the thermoablative service. Both of these cases are expected to exceed the ability of the Cancer Alliance to fund.
Q2	Commission evaluation partners Other milestones dependent on Q1
Q3	Deliver interim evaluation and commence sustainability assessment Other milestones dependent on Q1
Q4	Dependent on above

3.2 Treatment variation – National Cancer Audit Implementation

Deliverable	Alliances to oversee the implementation of one priority recommendation from each of 3 existing clinical audits for cancers other than lung cancer: • Breast: Breast cancer surgical teams should examine their reoperation rates after breast conservation surgery to identify areas where reoperation rates can be reduced, whilst supporting safe breast conservation • Prostate: Investigate why men with high-risk/locally advanced disease are not considered for radical treatment • Bowel: Reduce variation in neoadjuvant radiotherapy treatment in rectal cancer patients undergoing resection, ensure evidence-based local radiotherapy policies are in place. *(NB. The oesophageal cancer treatment recommendation has now been stood down as a planning requirement for 23/24)*
Success measures	New metrics for 23/24 for bowel, oesophageal, prostate and breast are still in development, but for now see priority recommendations selected by the CAG for implementation.

Name and email of Cancer Alliance Lead Contact: Lisa Galligan-Dawson. lisa.galligan-dawson@nhs.net

Narrative plan for 23/24
Cancer Alliances should provide an overview of implementation plans for **each** individual recommendation

Priority actions have been shared with the pathway board clinical leads and pathway board managers. The new Associate Medical Director for FDS, OD and Inequalities will oversee treatment variation within their portfolio, adding strong clinical leadership to this work area.

Work plans to be agreed with each pathway board.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables - e.g. on boarding an analyst to support the work, access to data set up)

Q1	Work programmes to be agreed
Q2	Dependent on actions progressed
Q3	Dependent on actions progressed
Q4	Dependent on actions progressed

3.3 Personalised Care, PSFU and Psychosocial Support

Personalised Care

Deliverable	Ensure the following personalised care interventions are available for all cancer patients, and data is submitted to COSD for: • Personalised Care and Support Planning (PCSP) based on Holistic Needs Assessment (HNA) • End of Treatment Summary (EOTS)
Success measures	• Proportion of patients diagnosed with cancer who were offered or accepted a Personalised Care and Support Plan • Proportion of patients diagnosed with cancer who were provided with an End of Treatment Summary

Name and email of Cancer Alliance Lead Contact: Freya Driver – f.howle1@nhs.net

Narrative plan for 23/24

Each Trust in GM has an identified Personalised Care Lead who attends our Alliance led Personalised Care (PC) Leads Forum which has the role of operationalising the 23/24 planning guidance as well as a focus on the quality of the interventions.

Face to face workshop held in Feb 2023 to review planning requirements and create an action plan based on the reviewing the current gaps and challenges. All Trusts are completing a scoping document to detail by tumour group how each intervention is delivered and where it is recorded; this was used to identify what GM level support was required, and where there were gaps by tumour group and Trust.

PC clinical lead developed HNA & PCSP standards to be used by all teams when implementing and delivering these interventions. This will ensure consistency of quality and will also provide a framework for Trusts to conduct audits to inform recommendations for improvement.

A Trust level HNA/PCSP dashboard has been co-designed with the PC leads and is being developed with Trust BI teams to monitor performance.

The Alliance are collating all existing EOTSs in use from the GM Pathway Boards and reviewing to check whether there are any treatments that require a template to be developed, or whether the design needs to be re-reviewed with a focus on user involvement.

When the CancerStats dashboard includes the EOTS data the Alliance will use this to create data packs to be shared with the PC leads forum and will identify any tumour groups which require improvement.

Each Pathway Board has a section of PC deliverables included in their 23/24 workplans which have been co-developed with the PC team and Pathway Managers to deliver on the 23/24 requirements. They will also be the clinical expert group to support with encouraging engagement with

GM developed templates (EOTS), GM guidelines/standards (for HNAs & PCSPs) and provide feedback on how to improve performance for those tumour groups that show low numbers through data analysis provided by the PC team.

Plans to develop GM specific training/educational resources for specific workgroups to support knowledge and confidence in delivering quality personalised care.

Note: planned milestones are not required for this deliverable.

PSFU

Deliverable	Fully operational and sustainable PSFU pathways for all suitable patients in breast, prostate, colorectal and endometrial cancer
Success measures	Proportion of trusts in the Alliance that has operational PSFU protocols for all suitable patients, split by: • Breast • Prostate • Colorectal • Endometrial

Name and email of Cancer Alliance Lead Contact: Freya Driver – f.howle1@nhs.net

Narrative plan for 23/24
(Please identify trusts that do not yet have operational PSFU protocols. Plans and reporting in 23/24 are not required to cover implementation of digital remote monitoring systems)

PSFU protocols have been clinically developed and approved via corresponding Pathway Boards (which include representation from all Trusts that deliver services for that tumour group) for Breast, Prostate, Colorectal and Endometrial. These protocols have been used as the design models for the PSFU pathways built into Infoflex (DRMS) alongside an EoTS letter template and patient portal.

While Infoflex is in the process of being rolled out across GM clinical teams have implemented PSFU across a number of Trusts in the interim and are tracking using a spreadsheet, but this is labour intensive for CNS teams so for those that have not operationalised the protocol we have recommended they wait until Infoflex is live for their Trust to ensure no undue pressure on the workforce and increased clinical safety netting for patients that a DRMS provides.

Go live plan developed for 23/24 during Q1 & Q2 for all Trusts including data load testing with a staggered approach across GM to ensure sufficient support can be offered within each Trust and technical issues can be fixed quicker.

Personalised Care Leads forum (PC lead identified for each Trust) will support with operationalisation with clinical teams on the ground. Developed GM PSFU guidelines to be used by clinical teams to ensure services are set up to deliver PSFU e.g., adding clinic templates, PSFU patient letters, information on Trust websites for patients.

PSFU focused face to face workshop with PC leads to be arranged end beginning of q1 23/24 to review PSFU operationalisation guidelines for clinical teams and identify areas of support and education required for Alliance to deliver – tumour group specific training days, development of FAQ documents for Infoflex, review sessions with users and civica post go live.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables e.g. PSFU protocol is fully operational)

Q1	Agree phased plan by Trust and tumour group for implementation of PSFU in line with Infoflex go live – support clinical team training sessions & comms and engagement activities to promote Infoflex
Q2	Breast & Colorectal PSFU pathways fully implemented across all appropriate Trusts
Q3	Prostate PSFU pathways fully implemented across all appropriate Trusts
Q4	Endometrial PSFU pathways fully implemented across all appropriate Trusts. First data extracts from Infoflex for PSFU collated.

Psychosocial Support

Deliverable	Deliver the Cancer Alliances' psychosocial support development plan
Success measures	No specific measures will be set by the national team. Activities can be reported as part of the narrative section in quarterly returns

Name and email of Cancer Alliance Lead Contact: Freya Driver – f.howle1@nhs.net

Narrative plan for 23/24
(Please summarise the key actions, outputs and dependencies for this workstream, and include any approaches for addressing health inequalities. Ensure you cover what you intend to spend the relevant part of your SDF on)
Note: Psychosocial development plans should address the gap analysis which was part of 22/23 requirements

Work with mental health commissioning lead and the 2 key mental health providers within the LTC arm of the Talking Therapies services to move the project to initiation. Recruit to Project manager post and work up project documentation including EIA. Note SDF funding applies to 0.5WTE of an 8a project manager the remaining 0.5WTE and other project costs have been funded by Macmillan

Note: planned milestones are not required for this deliverable.

4 Workstream: Cross-cutting

4.1 Patient Engagement & Involvement and Experience of Care

Deliverable	• Patient Engagement & Involvement: Cancer Alliances to establish and maintain a people and community engagement structure to enable Coproduction throughout work programmes within the Alliance and in conjunction with local ICB's and Trusts. • Experience of Care: Cancer Alliances are asked to work with systems and trusts to ensure they use insight and feedback to develop and deliver coproduced (with people with relevant lived experience and staff) quality improvement action plans to improve experience of care.
Success measures	No specific measures will be set by the national team. Activities can be reported as part of the narrative section in quarterly returns

Name and email of Cancer Alliance Lead Contact: Patient Engagement & involvement – Anna Perkins anna.perkins4@nhs.net & Experience of Care – Freya Driver f.howle1@nhs.net

Narrative plan for 23/24
(Cancer Alliances should provide an overview of their work to improve experience of care; detailing the interventions across the whole cancer pathway including primary, secondary and tertiary care)

The Cancer Alliance will continue to develop and expand on its existing User Involvement Programme and a wider Public and Patient Involvement and Engagement Programme (PPIE) to ensure that public and patient voices are sought and incorporated into our work. This will also include working further with local community sector organisations to increase diversity of representation. The team will also support the increased uptake of experience of care surveys including the Quality of Life (QoL) and Cancer Patient Experience Surveys (CPES) in order to provide a suitable evidence base to consider what matters most to our patients and where improvements should be made.

As part of the Personalised Care Programme we are conducting a Health & Well Being (HWB) self-assessment with Trusts and localities to identify gaps in support which will also be informed by experience of care surveys as stated above. User task & finish groups will help to develop coproduced patient resources and identify content for HWB events and educational materials for healthcare professionals. MIAA conducting an audit with cancer commissioners to review demand and capacity on cancer support services across GM.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables - e.g. develop communication plans for CPES, identify and build relationships with trusts, support ensuring that the required sample is completed for CPES)

Q1	Recruitment of Band 7 PPIE Manager HWB self-assessment survey to be shared with PC leads, Pathway Boards, CNS groups and Macmillan centres.
Q2	Development of PPIE programme and current UI programme at the Cancer Alliance including refreshed education and toolkit to support more teams with meaningful coproduction Review outputs of HWB self-assessment & user T&F groups established to address key gaps identified and take forward recommendations
Q3	Development of local relationships with community sector organisations to increase diverse representation within PPIE Quality evaluation co-produced with UI to assess HWB support offers
Q4	Increased drive in recruitment to our PPIE options – including national surveys and enrolment onto our PPIE programme

5 Other Local Projects

5.1 Additional local projects

Please use this space if you would like to detail any local projects where you will use your place-based SDF to undertake work not already described in narrative plans:

The tackling health inequality work will be led through our Health Inequalities Programme Board, the Board is currently refreshing its strategy which is due to go to Cancer Board in May 2023. The action plan that is developed from the strategy will be overseen by the Programme Board and delivered by a number of task and finish and subgroups.

The Cancer Alliance will meet all the health inequality asks as stipulated in the planning guidance, commentary on this has been provided in the relevant sections. On top of this the Cancer Alliance will also continue to work on reducing health inequalities in all our work, with further embedding and development of our EIA process. The Cancer Alliance will continue to work with the Population Health team and Integrated Care Board on the Core20Plus5 and Build Back Fairer frameworks.

The Cancer Alliance has a leading data function, supporting in particular the work in FDS and Operational Delivery, Early Diagnosis and Health Inequalities. There is an expansion to the function, working more closely on clinical outcomes data and evaluation. This work includes health economics, to support sustainability cases, and recognised assessment of interventions. Throughout 23/24 the data function will be developed to support the changing needs of the Cancer Alliance and the ICB.

The Cancer Alliance are represented on and significantly engaged in the work of the GM Elective Recovery & Reform Board to ensure where cancer and elective pathways align, the solutions are designed and delivered jointly. The Cancer Alliance are also working as part of the GM vulnerable services network to jointly address issues with breast and dermatology/skin pathways.

5.2 Workforce initiatives

Please use this space to detail any workforce projects:

To support the growth of the cancer workforce the cancer alliance has developed a regional Cancer Workforce strategy underpinned by the one workforce ambition. The activity in the strategy will support delivery of the cancer objectives by focusing on initiatives to attract more people into a career in cancer, including generalists, and ways to retain the current workforce throughout the career trajectory. The following initiatives will be prioritised over the next 12 months:

- Leading the implementation of the National ACCEND framework locally to support recruitment and retention of the non-medical workforce including Cancer support workers (care coordinators and navigators), CNS', and Allied Health Professionals.

- Exploring innovative workforce solutions to support the delivery of Best Practice Timed Pathways.

- Working with Education providers to promote careers in cancer.

- Developing a clear route into cancer: to be piloted for Cancer CNS' i) piloting a cancer placement model, ii) rollout of the aspiring CNS programme, iii) pilot CNS preceptorship to support CNS' new in post, iv) legacy mentors to retain experienced CNS' later in their career.

- Piloting blended roles to improve integrated working across primary and secondary care e.g. Physician Associates (PA). The PA will be upskilled in urology so that they can support PCNs with prostate cancer case finding to support early diagnosis, and with managing urological cancers within the community.

- Expanding cancer fellows across different sectors and different professional groups: GP Cancer fellows, Practice nurse cancer fellows, Junior Doctor cancer fellows to a) attract larger numbers into cancer and b) increase the no. of cancer champions across the system to support earlier diagnosis and improve patient experience.

- Establishing a single cancer education hub – GM Cancer Academy – one stop shop for generalist and specialist professionals to reduce inequity in access to cancer education, standardise education, and reduce variation in practice across the system.

- Strengthening links with Social Care and Mental Health providers through an academies network to provide and promote mutually beneficial education including education to support early diagnosis of cancer across the sectors, and improved integration.

- Piloting projects to reduce workforce inequalities.

- Improving collection of cancer-specific workforce data to a) inform workforce planning to ensure there is enough capacity in the system to achieve the 62 day target and meet the FDS, b) measure the impact of workforce initiatives, and c) inform future initiatives / areas of priority.

**please note the Diagnostics Networks and Operational Delivery Networks have separate workforce strategies / programmes of work, which the alliance keeps closely linked to and supports the delivery of where possible.*

Greater Manchester Cancer

Risk Register March 2023

ID	Domain (if applicable)	Date Raised		Owner	Likelihood	Impact	Score		Proximity	Further Action Planned.	Risk escalated to and by who	Date of Escalation	Likelihood	Impact	Score	Last reviewed
A unique coding that allows the risk to be easily identified	See list of domains below for key *		A statement describing the risk event, cause and impact	Job title of the person responsible for the management, monitoring, control and escalation where appropriate, of the identified risk			Current (see key below)	Trend	Timescale as to when the risk will occur	(Who, What, Why and when anything more will be done to reduce the residual risk)					Mitigated	Date last reviewed
	FD OpI	28.06.22	If the planned programme of recovery work is not delivered in full then the Faster Diagnosis standard will not be achieved by March 23 in line with planning guidance	GM Cancer Performance Director	5	5	25	↔	0-3 Mths	*BPTP to be implemented for Gynae/ H&N * Imaging network engaged to support recovery * Recovery panel established * Continuous focus on trajectories through COOs * New 'predicted' performance development on tableau allows proactive management with provider teams * Improvement initiative Nov 22 with c£650k of additional activity * FD workshop taken place, H&N USSFNA training planned for May 23	GM SORT, GM Cancer Board and PFB	Weekly GM SORT, Monthly PFB, Bi-monthly Cancer Board (lastest updates Jan 23)	5	5	25	06.03.23
	FD OpI	28.06.22	If the GM wide work programme and organisational improvement plans are not delivered in full, the backlog reduction target will not be delivered. This will impact the reputation of the ICB, Cancer Alliance	GM Cancer Performance Director	5	5	25	↔	0-3 Mths	* Recovery panel established * Ongoing work programme with Cancer Managers. Focus on longest waiters, supported by COOS for GMCA to lead. * FIT and dermatascope work to support demand management and faster pathways * Modelling refresh and agreed treatment trajectories * System wide oversight of P2 cancer activity * CTC workshop follow up planned 05.12.22 * Surgery Trajectory Agreed and revised approach to use of mutual aid * Delivery Officer role recruited to	GM SORT, GM Cancer Board and PFB	Weekly GM SORT, Monthly PFB, Bi-monthly Cancer Board (lastest updates Jan 23)	5	5	25	06.03.23
	Wf & Ed	23.6.22	If there is not sufficient workforce capacity in the system then we will not be able to deliver the recovery of cancer services and the long term plan ambitions for cancer.	Programme Director for Workforce and Education	5	4	20	↔	12+ Mths	• New strategy out for consultation starting wk 6.3.23 • Alliance cancer workforce narrative in planning guidance also included in the ICB submission • Reviewing the governance and reporting mechanisms for the wf and ed programme will follow once the strategy has been signed off •Drive forward the cancer academy as the hive of education for GM and delivery of the Education Collaborative principles to support retention by ensuring equity in access to cancer education for both generalists and specialists, and to attract the future workforce • Developing career frameworks for CNS, AHPs, CSW to improve recruitment and retention • Continue to strengthen links across all healthcare sectors to achieve true integrated cancer care and work towards a one workforce model • Continue to pilot new roles / blended roles to bring extra capacity across sectors and working with HRDs to scale and spread these roles accordingly	Spotlight at the February Strategy and System Risks Assurance Group - GM Cancer		4	3	12	06.03.23

	FD Opl	05.10.22	If there is a lack of engagement with managing referrals into breast services including the re-direction of non urgent symptoms into alternative pathways e.g. mastalgia, along with inability to expand the breast cancer workforce (specifically radiology), then there will be a failure to meet cancer waiting time standards across GM for breast which will significantly impact the overall performance for all tumour groups	Programme Director for Transformation	5	4	20	↔	0-3 Mths	Support Breast Cancer Pathway Board team to implement a mastalgia pathway in all 6 Trusts across GM over the next 12-24 months. New project manager in post November 2022 to progress mastalgia pathway development and support GPwER pilot. Support the pilot of GPwER funded by HEE which aims to provide support in capacity for mastalgia pathway and ETIP (Endocrine Therapy). Recruitment of 6xGPwER Nov22-Feb23 (5 successful candidates accepted, 2 to start early March, last interview 27th Feb). Induction documentation, competency framework etc. all developed. Regular highlight report on progress to be completed and shared via SL with HEE. A workforce development plan for Breast Radiology was developed to address the gap of 3% growth against the national standard which has not been funded. Support the funding for the development of the radiology workforce to prevent other unit closures. Continuing to explore potential funding with screening team for fellowship x 3 and AP development courses - information sent Feb23. Longstanding discussions regarding reconfiguration of services has led to a lack of investment in estates for Breast services, MFT WTWA are the largest provider for Breast cancer care in GM and they have a significant issue with space which is directly leading to a lack of capacity for clinics. Any workforce development plans must be supported with the development of estates to ensure sustainability of services. Resilience meetings across GM from 2019 - 2021, led to development of PFB Task and Finish Group from November 2021. Short-Medium term resilience solutions proposed to PFB February 2022. PFB Task and Finish Group was led by Jane Eddleston (MFT), two workshops were held to develop the proposal which was signed off in Feb 2022. All further delivery of the solutions is being overseen by the pathway board and an update paper will be produced for PFB by end of Feb 2023. Paper not developed as yet due to resource, aiming to provide update in March/April 2023. Met with ICB Vulnerable Services lead in Feb23 to discuss Model of Care and GPwER pilot.	PFB, by CG/CG	11/02/2022	3	4	12	02.03.23
	FD Opl	06.03.23	If industrial action continues at the planned rate, there will be a significant impact to cancer delivery impacting operational perforance baselines, and pathway milestones	GM Cancer Performance Director	4	4	16	new	0-3 Mths	Unable to mitigate the industrial action risk. Ongoing work to maintain the profile of cancer delivery for those with cancer and those suspected of having cancer and awaiting outpatients, diagnostics and reporting	GM SORT, PFB	Feb-23	4	4	16	06.03.23
	Wf & Ed	21.11.22	If all GM trusts take part in the planned industrial strike for numerous different professional groups then this will impact on all GM Cancer programmes of work	Programme Director for Workforce and Education	3	5	15	↔	3-6 Mths	Members of the GM Cancer Senior Management Team attend key system groups including SORT, where strike action is discussed in detail. Potential impact on cancer services can be monitored through these meetings and allow the alliance to respond accordingly.			3	4	12	6.3.23
	PC	10.10.23	If the technical support and data processing process is not agreed and approved with GM Digital (host platform) on behalf of GM for the new DRMS before infoflex go live then Trusts will disengage and data will not be accessible	Programme Director for Personalised Care	5	3	15	↔	0-3 Mths	• GM Digital are still to provide SLA/service desk arrangements for GM (have been requesting for 6 months +) - Trusts require this to be in place before go-live. PC PM has been actively chasing GM Digital and ANS since starting in November. • Recommendation to fund 1 extension of licences (to March 24) for infoflex to support embedding PSFU and rolling out SQD (using same system) has been approved and funded. • Main contact (Jon Burt) has left mid December with no handover. Met with Keiran (GM Digital Programme Lead) who has picked up gaps in support and has been reviewing outstanding issues eg SLA and agreement of roles/responsibilities of digital partners post go live. • Alliance to fund system specialist role to sit within Christie IT Apps/eforms team to support infoflex - progressed with Christie and shared JD (based on existing Christie roles) with plan to recruit or identify internal existing candidate. • Exploring option to move hosting arrangements away from GM Digital given massive delays in agreeing SLA and lack of resource to support a GM wide system - to be discussed at Digital Planning meeting.	Escalated to Assurance board in lieu of PC Programme Board or GM Cancer Digital Strategy Board	08/02/2023	4	3	12	06/03/23

	F/All	06/03/23	If the Cancer Alliance do not ensure clear exit strategies are in place once Alliance SDF or Targeted funding has expired, the Alliance will put the GM system at significant financial risk and risk ongoing delivery of improvement projects implemented by the Alliance	Director of Commissioning & Early Diagnosis	3	5	15		6-9 Mths	All Programme Leads to ensure exit strategies in place before the end of Q1 2023-24							06/03/23
	FD Opl	06.03.23	If the recovery programme of work is not delivered in line with 23-24 plans, then the cancer alliance and GM system will not deliver the end of March 24 backlog reduction planning requirement	GM Cancer Performance Director	3	5	15	new	3-6 Mths	Full work programme being developed to support delivery; however it is acknowledged that with competing operational pressures, delivery will be challenging	ICB - planning round	Mar-23	2	5	10		06.03.23
	FD Opl	06.03.23	If the recovery programme of work is not delivered in line with 23-24 plans, then the cancer alliance and GM system will not deliver the end of March 24 FDS planning requirement	GM Cancer Performance Director	3	5	15	new	3-6 Mths	Full work programme being developed to support delivery; however it is acknowledged that with competing operational pressures, delivery will be challenging	ICB - planning round	Mar-23	2	5	10		06.03.23
	FD Opl	06.03.23	If the financial deficit for NSS is not resolved, then there will be a significant shortfall in resource for allocation in FD Opl that will prevent planned improvement work (funds pre-committed to NSS / RDC and planning guidance now requests differing focus)	GM Cancer Performance Director	3	5	15	new	0-3 Mths	Ongoing work to resolve	N/A - Internal discussion presently	N/A	3	5	15		06.03.23
	PC	23.6.23	If there are continued delays with the implementation of a DRMS then we will not meet national targets within the planning guidance delivery plan	Programme Director for Personalised Care	4	3	12	↔	0-3 Mths	• Refreshed meeting schedule and governance overseeing progress of DRMS implementation with all key digital partners involved - ANS (connectivity), Civica (build) and GMCA (hosting & helpdesk) • approval process for modules (GM Cancer structure, clinical and patient) agreed and implemented more robustly - 4 key PSFU pathways in 23/24 cancer planning designed, approved and built on infoflex • Estimated timeline for go live rollout of infoflex by Trust worked through with civica - recently impacted by issue with firewall updates (ANS) not being progressed but this is being resolved. • PM working with each Trust to support testing phase pre-go live and joining CNS training sessions for infoflex to identify any areas of concern. • New cancer planning guidance for 23/24 has specific requirements re; DRMS rollout however this should not impact Alliance plans given investment and linked delivery of PSFU. • Update from Stockport - Confirmation from COO at locality visit that Stockport will work with civica and Alliance to implement infoflex	Escalated to Assurance board in lieu of PC Programme Board	08/02/2023	3	3	9		06/03/23
	F	23.6.23	If funding is not available in 2023-24 for projects which require ongoing funding from the GM system then projects will have to cease or find alternative options for sustainability	Individual project manager / domain lead and co-ordinated by Director of Commissioning	3	4	12	↔	3-6 Mths	Need to reconsider this risk in the context of the planning for 2023-24 and have a robust process in place for each programme to identify and manage future funding requirements Recommend to PAG removing this risk and replace with new risk identified below			2	3	6		06/03/23
	CC	23.6.23	If the cancer Alliance do not deliver on recovery of cancer services and the priorities outlined in the NHS LTP and the annual operational planning guidance then this will negatively impact on the reputation of the organisation.	Associate Director	3	4	12	↔	3-6 Mths	Identified SMT Lead for each domain within the planning guidance responsible for delivery oversight incl budget and flagging of associated risks to delivery Strong system links in existence to support delivery and escalation			2	4	8		03/03/23
	PC	23.6.23	If data is not accurate then we will not be able to reliably report performance to NHSE.	Programme Director for Personalised Care	3	3	9	↔	0-3 Mths	• Trust PC leads to complete gap analysis of each PC intervention by tumour group - how it is delivered and where/how it is recorded - to understand baseline of quality before developing individual plans to improve. • f2f workshop 5/2 with Trust PC leads (high turnover of identified leads) - reviewed gap analysis and agree GM delivery plan for PC leads forum as well as local plans for each intervention. • New cancer planning requirement for 23/24 has removed performance monitoring of overall numbers but instead there will be focus on increasing conversion of HNAs to PCSPs and EoTS activity. • Developed dashboard metrics with PC leads for HNA & PCSPs- each Trust will work with BI teams to develop to view and analyse more accurate timely data (as not all activity recorded via COSD which is the national data source for performance)	Escalated to Assurance board in lieu of PC Programme Board	08/02/2023	3	2	6		06/03/23
	ED	23.6.23	If funding is not available to continue the Cancer Alliance programme of work on Early Diagnosis in 2023-24 then the ability to improve the position on stage of diagnosis in GM will be significantly impacted as will therefore the achievement of the LTP target of 75% by 2028	Director of Commissioning & Early Diagnosis	2	4	8	↔		Maintain the profile of the ED programme within the Cancer Alliance and GM system. Monthly ED Steering Group meetings with reports on progress and risk to GM Cancer Assurance Group. Regular progress report to GM Cancer Board and localities. GM locality meetings to engage in and raise the profile of Early Diagnosis as a key LTP project. 10 x Locality meetings arranged and progressing - 7 to date. Remove and replace with new risk below for 2023-24			1	3	3		06/03/23
	HI	23.6.23	If funding is not available to continue this programme of work in 2023-24 then the ability to improve the position on inequalities in cancer care in GM will be significantly impacted	Director of Commissioning & Early Diagnosis	2	4	8	↔		Maintain the profile of the Inequalities programme within the Cancer Alliance and GM system. Monthly Health Inequalities Steering Group meetings with reports on progress and risk to GM Cancer Assurance Group. Regular progress report to GM Cancer Board and localities. NHS GM IC Medical Director leading a piece of GM wide work on inequalities and the Cancer work is included. Session December 2022 to review and refresh the Cancer Alliance strategy. Joint work with the NHSE/I Section 7a Screening Imrovement Team on uptake of screening in protected characteristic groups			1	3	3		03/02/23
	ED	23.6.23	If localities do not engage in the Early Diagnosis programme of work then the impact will be less than the plans cite	Director of Commissioning & Early Diagnosis	2	3	6	↔		Maintain the profile of the ED programme within the Cancer Alliance and GM system. Monthly ED Programme Board meetings with reports on progress and risk to GM Cancer Assurance Group. Regular progress report to GM Cancer Board and localities. GM locality meetings to engage in and raise the profile of Early Diagnosis as a key LTP project. Planning guidance 23/12/22 highlights LTP Ambition as a key priority for 2023-25			1	2	2		06/03/23

Key

Likelihood

1 **Very low:** Only occurs in exceptional circumstances.

2 **Unlikely:** Expected to occur in a few circumstances.

5	10	15	20	25
4	8	12	16	20

3 **Possible:** Expected to occur in some circumstances.
4 **Likely:** Expected to occur in many circumstances.
5 **Almost certainly:** Expected to occur frequently.

3	6	9	12	15
2	4	6	8	10
1	2	3	4	5

Impact

1 **Negligible:** No noticeable impact on day-to-day operations. No impact on reputation / no media interest. Complaints unlikely.
2 **Minor:** May have a slight impact on day-to-day operations but can be easily resolved**.** Slight impact on reputation with some localised, low level negative impact. Low level of complaints.
3 **Moderate:** Some disruption to day-to-day operations requiring management discussion / intervention. Potential for adverse publicity but of limited scope and duration that can be managed. Generates a limited number of complaints.
4 **Major:** Disruption of day to day operations requiring executive input and notification to the Board. Adverse publicity including some national press. High number of complaints. Could impact on ability to influence.
5 **Catastrophic:** Day to day operations disrupted for prolonged period**.** Wide loss of supporter / beneficiary confidence. Major and widespread adverse publicity.

Proximity

X As well as measuring the likelihood and the impact of a risk, it is important to assess its proximity, i.e. when the risk is likely to occur:
1 Imminent: within the next 4 weeks.
2 In the next 3 months
3 In the next 6 months
4 In the next 12 months

*** Domains**

FD OpI Faster Diagnosis and Operational Improvement (incl treatments)
ED Early Diagnosis (incl prevention)
PC Personalised Care
Wf & Ed Workforce and Education
F Finance
HI Health Inequalities
C&E Comms and Engagament (inc pt experience)
CC Cross-cutting

Financial Performance 2022-23

Recap of SDF & Targeted Income for 22-23

Description	£000
Service Development Funding (SDF)	8,285
NHS Cancer Screening, targeted case finding and surveillance: Targeted Lung Health Checks (Manchester, Salford, Tameside & Glossop)	4,674
NHS Cancer Screening, targeted case finding and surveillance: Lynch	359
Innovation: Colon Capsule Endoscopy	320
Innovation: Cytosponge	185
NHS Cancer Screening, targeted case finding and surveillance: Liver	TBC
Primary care Pathways: targeted case finding for prostate cancer; direct referral from community pharmacy	TBC
TOTAL	**13,823**

Greater Manchester Cancer

Summary

Category	Year End Forecast
Pay	3,082,721
Non Pay	14,670,259
Inter Divisional transfers	293,890
External Income	(1,704,765)
SDF & Targeted Income	(16,341,886)
Total	**220**

Greater Manchester Cancer

Service Development Funding

	Category	Annual Allocation	Year End Forecast
Early Diagnosis			
	Pay		537,900
	Non Pay		1,605,726
	Inter Divisional Transfers		504,106
	External Income		(247,250)
	SDF	2,402,650	(2,402,650)
Total			**(2,168)**
Treatments and Personalised Care			0
	Pay		226,105
	Non Pay		250,332
	Inter Divisional Transfers		248,779
	External Income		(11,922)
	SDF	715,919	(715,919)
Total			**(2,625)**
Faster Diagnosis/ Operational Performance			0
	Pay		670,890
	Non Pay		5,991,297
	Inter Divisional Transfers		481,038
	External Income		(607,253)
	SDF	4,274,375	(6,544,375)
Total			**(8,403)**
Cross Cutting			0
	Pay		1,647,826
	Non Pay		1,055,831
	Inter Divisional Transfers		(940,033)
	External Income		(838,340)
	SDF	892,056	(892,057)
Total			**33,227**
Grand Total		**8,285,000**	**20,031**

Greater Manchester Cancer

Targeted Funding

	Category	Annual Allocation	Year End Forecast
THLC			
	Pay		0
	Non Pay		4,674,000
	Targeted Funding	4,674,000	(4,674,000)
Total			**0**
CCE			
	Pay		0
	Non Pay		257,395
	Targeted Funding	320,000	(266,057)
Total			**(8,661)**
Cytosponge			
	Pay		0
	Non Pay		143,500
	Targeted Funding	185,000	(150,036)
Total			**(6,536)**
Lynch			
	Pay		0
	Non Pay		354,814
	Targeted Funding	359,422	(359,428)
Total			**(4,614)**
Early Diagnosis - Prostate & Pharmacy			
	Pay		0
	Non Pay		337,366
	Targeted Funding	337,365	(337,365)
Total			**0**

Greater Manchester Cancer

GM Cancer Alliance 23-24 Funding	£
Service Development Funding	13,607,311
NHS Cancer Screening, targeted case finding and surveillance, Lynch	359,422
NHS Cancer Screening, targeted case finding and surveillance, Liver	326,575
Innovation Colon Capsule Endoscopy	233,481
Innovation Cytosponge	163,116
Primary Care pathways, targeted case finding for prostate cancer	302,750
Primary Care pathways, targeted case finding for direct referrals community pharmacy	65,000
NHS Cancer Screening, targeted case finding and surveillance, Targeted Lung Health Check	7,416,100
Total	**22,473,755**

Greater Manchester Cancer

Personalised Care

Freya Driver
Programme Director for
Personalised Care

Highlights / Update – Personalised Care

Updated Cancer 23/24 planning guidance deliverables:

- Personalised Care: Ensure the following personalised care interventions are available for all cancer patients, and data is submitted to COSD for:
  - Personalised Care and Support Planning (PCSP) based on Holistic Needs Assessment (HNA)
  - End of Treatment Summary (EOTS).
- Psychosocial Support: Deliver the Cancer Alliances' psychosocial support development plan.
- PSFU: Fully operational and sustainable PSFU pathways for all suitable patients in *breast, prostate, colorectal and endometrial cancer.*

All Trusts now have an identified Personalised Care Lead to progress with operationalising and implementing the personalised care deliverables as stated above.

Developed an Alliance and Trust level action plan to support implementation of HNA/PCSP standards, PSFU guidance and improve uptake of GM treatment summary templates across all Trusts.

Key areas of focus identified by Trust leads:

- Promotion of importance of personalised care within Trusts and at a system level – align with elective recovery
- Agree standards for HNA & PCSPs to use across all GM Trusts to improve consistency and support analyse of performance
- Develop educational resources and provide central platform freely accessible and visible for different workforce groups – CNS, AHPs, Research staff, non-medical workforce
- Centralise visibility of HNA & PCSP data across GM to identify best practice and areas for improvement

PSFU protocols for Breast, Prostate, Colorectal and Gynaecology (including Endometrial) clinically developed and approved by Pathway Boards and built onto infoflex platform.

- Trusts have been asked to provide plans for live use of infoflex by tumour group for the key pathways as above
- Alliance will then co-ordinate staff training/engagement events to support clinical teams

Other highlights:

- GM Genomics event planned for October '23
- H&WB self assessment survey shared with Trusts to collate and have visibility of what is offered across GM
- LWWC Programme Manager interviews held 17/3/23

Greater Manchester Cancer