GM Cancer – Cancer Board Agenda

Meeting Time and Date: Monday 15th May 2023, 15:00-17:00
Venue: Frank Rifkin Lecture Theatre, Level 1 Mayo Building, Salford Royal, Stott Lane, Salford, M6 8HD
Meeting Chair: Roger Spencer

	Item	Type	To	Lead	Time
1	Welcome and apologies Minutes from previous meetings - 27th March 2023 Action log review	Verbal Paper 1	- Approve Update	Roger Spencer	5’
2	Update on GM ICB System Review - Leadership and Governance	Verbal	Update	Roger Spencer	10’
3	GM Workforce Strategy	Presentation / Paper 2	Update	Suzanne Lilley	15’
4	Faster Diagnosis & Operational Improvement and Treatment	Presentation / Paper 3	Update	Lisa Galligan-Dawson	15’
5	Personalised Care	Presentation	Update	Freya Driver	15’
6	Early Diagnosis	Presentation	Update	Alison Jones	15’
7	Locality Visit Report	Paper 4	Update	Alison Jones	15’
7	Health Inequalities Strategy	Presentation / Paper 5	Update	Dan Clarke	15’
8	Papers for information: - Q4 Quarterly Return 2022/23 - Cancer Alliance Planning Guidance Return 2023/24	Paper 6 Paper 7 / 8	Inform Inform	Alison Armstrong Alison Armstrong	-
9	AOB	-	Discuss	All	15’

The next meeting is scheduled for Monday 17th July 2023 at The LifeCentre, 235 Washway Road, Sale, M33 4BP

Greater Manchester Cancer Board
Minutes and Actions

Meeting time and date: Monday 15th May 2023 15:00 – 17.00
Venue: Salford Royal Mayo Building, Stott Lane, Salford, M6 8HD

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
Lisa Galligan-Dawson	Performance 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
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
Susannah Penney (SP)	Associate Medical Director	GM Cancer Alliance
Freya Driver (FD)	Director of Personalised Care	GM Cancer Alliance
Nabila Farooq (NF)	Service User Representative	GM Cancer Alliance
Anna Perkins (AP)	Communications and Engagement Lead	GM Cancer Alliance
Janelle Yorke (JY)	Chief Nurse	The Christie NHS Foundation Trust
Vicky Sharrock (VS)	Programme Lead	GM Provider Federation Board
Caroline Davidson (CD)	Director of Strategy	Manchester University NHS Foundation Trust

In attendance		
Name	**Role**	**Organisation/Representation**
Dan Clark (DC)	Health Inequalities Project Manager	GM Cancer Alliance
Christian Franchi	Senior Team Administrator	GM Cancer Alliance

Sarah Carr	Senior Team Administrator	GM Cancer Alliance

Apologies		
Name	**Role**	**Organisation**
Manisha Kumar	Medical Director	NHS GM Integrated Care
Roger Prudham	Lead Cancer Clinician representative	Northern Care Alliance NHS Foundation Trust
Rob Bristow	Director / Research Representative	Manchester Cancer Research Centre
Claire Trinder	Director of Research Operations and Strategy	University of Manchester
Janet Crofts (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
Anita Rolfe	Co-Chair / GM Place Lead Representative	Stockport CCG
Martyn Pritchard	Managing Director	GM Provider Federation Board
Denis Colligan	GP / Macmillan Representative	Macmillan Cancer Support
Rob Bellingham	Director of Primary Care and Strategic Commissioning	GM NHS Integrated Care

1. Welcome and Apologies	
Discussion summary	RS welcomed everyone to the meeting and invited AA to note apologies, to which she reported the apologies as listed in the first part of this document. RS asked if there were any activities associated with the minutes of the previous meeting that anyone would like to draw attention to; to which there was no response. DS noted that Ed Rose, Director of Delivery for the NHS Cancer Programme, is going on a tour of Cancer Alliances, visiting the GM Cancer Alliance on the 5th June (now rescheduled to 24th July). He added that there are several board members in attendance for his visit, including RS. RS asked for approval of the minutes from the previous meeting and noted the action log activities. The minutes were approved by the attendees.
Actions and responsibility	Nil of note.

2. Update on GM ICB System Review – Leadership and Governance	
Discussion summary	RS reminded colleagues of the attendance of a representative from Carnall Farrar at the last GM Cancer Board (board) meeting who spoke about the Integrated Care Board (ICB) review. He noted that the activities associated with the outcome of the review will be taking place shortly and the GM

	Cancer Alliance, as part of the GM system, will be part of this. These activities will also be associated with the financial review by PricewaterhouseCoopers (PwC). He added that it was important to keep the board up to speed on this topic as the system boards will be key components of the governance of financial matters moving forward. ED noted that it was clear this year was going to be difficult regarding the planning phase running into the submission of the financial plan. He confirmed that a plan had been submitted which did not conform to compliance requirements along with some of the key performance areas such as mental health and elective waiting times. Cancer was noted as a high risk for delivery. A new plan has been submitted which has more risk but with a zero result; this risk equates to about £600m with an actionable value of about £130m which will be tackled by working with other organisations. As this is a system solution, it has been agreed that for there will be a system recovery plan assembled. ED noted there are three strands of work within the recovery plan; assurance around organisational Cost Improvement Programmes (CIPS), a tricky decisions list and a series of work programmes which are short to medium or long-term programmes to find a better financial situation. PwC did some work on this previously which noted problems such as workforce issues and a drop in productivity in the areas that need to be progressed. Programmes are being worked on that respond to those drivers. RS confirmed there will be a process of developments that the board will be presented with, including hard substance to the things most relevant to the board. This will contribute to improvement in the areas of the system which work together. COR notified the board members that the board Directors will be meeting with their ICB colleagues over the coming months on this topic.
Actions and responsibility	An update on the GM ICB System Review to be brought back to next GM Cancer Board meeting.

3. GM Workforce Strategy	
Discussion summary	RS indicated that the GM Cancer Workforce & Education Strategy had been circulated for information before the meeting. SL presented her slide and noted that the main purpose of her presentation was to talk through the refreshed strategy and request approval from the board before wider dissemination. She added that the main strategy was signed off in 2021 but is being refreshed due to the NHS Integrated Care Partnership refreshing their People and Culture Strategy. SL explained the process that the strategy had taken including wide system engagement featuring workshops with stakeholders; after which the paper went out for consultation at the end of March 2023. It was circulated through partnerships and networks such as the GM People board ending in agreement from all stakeholders, including HR Directors. SL confirmed a delivery plan will be created for the strategy in due course. SL went through the 'Strategy Priorities' part of her slide which she noted were part of the People and Culture Plan. She added that there was a 5th pillar which was more applicable to employers, therefore not included, but certain points from that pillar were included elsewhere. SL noted that she will be having a discussion with Directors for the HR piece in due course and asked for any questions from the board.

	RS enquired after the timeframe for the delivery plan to which SL confirmed it is currently being worked on and will cover the next 12 months. SL confirmed that she will endeavour for the delivery plan to be circulated at the next board meeting. JP noted an opportunity for a conversation at the People Board as there are number of academies in the area with different approaches. There is a discussion to be had on what each of these offers, how they align and how to make their offers easy to navigate. SL agreed this would be a good approach and confirmed she is already linking in with the Social Care Academy. JP confirmed that she would take this back to the People Board. DS added that there needs to be more done for not just workforce but for patients and carers and how they are supported. There is too much work for the workforce to do, so the patients need to be enlisted to do more.
Actions and responsibility	Nil of note

4. Faster Diagnosis & Operational Improvement and Treatment	
Discussion summary	LGD started her presentation by noting that the latest Cancer Waiting Times for March were not available at the time the paper was drafted. She went through the current performance section of the slides, comparing performance versus the NHS target of 761, which was an adjusted figure. Regarding the Faster Diagnosis Standard (FDS), the March position finished at 74.4% (a whisker away from the desired figure of 75%) with a trajectory of 75.1%. LGD mentioned the other key standards from a 62-day perspective which have made unexpected inroads. The current figure of 62.4% is positive and above the national average for 62-day performance. There is a deterioration in both the 31-day requirement and the subsequent surgery delivery, which is linked to Tier 1 organisations supported by the GM Cancer Alliance (alliance). Improvements have been made and should be commended; sustainability is the issue. There was deterioration in the backlog due to strike action and Bank Holidays, with issues regarding Skin which remain a key challenge. LGD highlighted this as a risk to FDS and the backlog. LGD commented that for some organisations the performance at end of March was better than the April forecast. She added that diagnostics had been another area of risk, with much of the improvement taking place with diagnostics in mind. AA is working on this issue, but it is also worth noting that it remains the key challenge along with Skin and Gynaecology. LGD explained that Community Diagnostic Centres (CDCs), where more activity is being seen, are being scaled down which poses questions on which Pathways should have additional improvements. RS asked for any questions and noted that the point on diagnostics refers to broader diagnostics, of which only about 5% turn into a Cancer pathway but they have an impact on achieving the diagnosis standard. LR noted the target on diagnostics is out of sync, as in the Northern Care Alliance (NCA) they can all good improvements can be erased with the position on dermatology due to the high volume of patients in general. ED recognised the improvement from early 2022 until now and endorsed the principle that people were ending the financial year ahead of the Q1 trajectory. He proposed that the presence of the

	Referral to Treatment (RTT) target is imposed during this year which will come back as a primary objective in coming years. LGD confirmed she knew that this would be part of the planning guidance and for the FDS percentage to go up with specialty targets. The national performance approach is shining on the successes of the tiering process and a couple of these key points are going to come back round through a tiering approach by NHS England. She noted the tiering approach regarding waiting times hitting the abolition of the 2-year waiters, and how it is now an 18-month track added as a Cancer target due to the prioritisation of the two. VS commented that the tiering process has helped drive down long waits but it has impacted the wider system which is not always a positive. She noted her worry that there is an immediate June target on the 78-week wait and then straight into the 6- week wait towards the end of next March. These targets will make the RTT pathway more intense. Regarding diagnostics, the trajectory for that is focused on RTT pathways but the demand and capacity work needs to focus on Cancer and elective together. There is a piece of work the diagnostics board needs to do, to make sure it targets both areas and makes no reciprocal negative impact.
Actions and responsibility	Nil of note

5. Personalised Care	
Discussion summary	FD introduced her slides and firstly noted that several workshops were held on the deliverables of Personalised Care, looking at topics by Trust and tumour group. Using the guidelines which were produced by the Clinical Lead, a plan for each of the interventions for the year has been created. For example, the End of Treatment Summaries (EOTS) are being discussed to find a way to agree which Trust is due to complete them. This is a project which has been worked on with Trusts and Clinical Nurse Specialist (CNS) teams to then take through the Pathway Boards to ratify. FD explained that there were detailed action plans for each intervention, that the Trust Personalised Care leads will act upon within their Trust. FD commented on the feedback from the workshops, which offered increased visibility of Personalised Care, the promotion of its importance and help within the healthcare system. She added there will be a strong communication and engagement plan within which educational resources will be centralised. She noted the implementation of a nationally developed outpatient appointment tool which offers a way to estimate the impact of Patient Stratified Follow Up (PSFU) on outpatient appointments. This may be limited by the lack of centralised view of the data but there are several systems that the data can be input into. FD is working with each trust to create a dashboard for this. For PSFU, key pathways have been ratified as well as five additional pathways through Pathway Boards. There is currently a large variation around where PSFU is in use, so the Personalised Care Leads have been asked to compete an audit to understand how it is operational. This will help to plan when they are ready to clinically adopt in line with InfoFlex. Regarding other highlights, FD noted the Genomics event planned for October 2023 which will focus on clinical aspects. She added that the Living Well with Cancer Manager started in post the previous week and the team were working with ICB around person-centred care.

	FD referred to the infographic on her slide which was developed for Personalised Care with patients in mind. The intention of the infographic was for it to be disseminated widely to promote understanding of Personalised Care. LR enquired after where the follow-ups and InfoFlex were up to and noted that she would like to see that information come through the Chief Operating Officers (COOs) meeting. She noted her concern that no-one seems to be looking at follows ups and the attention is now being paid to new Pathways. FD explained the approach taken, and the plan on improving the system regarding follow ups. COR noted that a paper is going to COOs noting the totality of improvement plans on diagnosis and if there is something specific required on the update, CG can report as the Personalised Care Clinical Lead. DS noted that, although FD's work is about cancer, PSFU lends itself to other areas as well. This initiative is going to underpin the system going forward and will be shared. There are system areas which have piloted similar applicable initiatives that can also be shared.
Actions and responsibility	Nil of note

6. Early Diagnosis	
Discussion summary	AJ introduced her slides and noted that the backdrop to the Early Diagnosis work was to diagnose 75% of patients at stage 1 or 2 by 2028. She noted that the Rapid Cancer Registration Data was the latest received. As RS alluded to in board meetings, there is rapid cancer registration data available on tumour site at provider level or GM level, but it is not yet comparable to other areas. AJ noted that the Business Intelligence (BI) Team are working to get the raw data behind this to offer a comparison. This data is available on Tableau, a link to which AJ will circulate with the board documents. AJ explained that from this data it will be easy to see which pathways will need attention to get to the required level by 2028. She noted that the drops in figures in Q2 22/23 are due to a data completeness issue and the latest quarter of data is not complete. Looking at the most reliable data, which is Q3 22/23, it notes 57% which is a significant improvement, a helpful tool that can be used to work with Pathway Boards and others on how to focus effort. AJ is getting a message to Pathway Boards via CG to note the availability and significance of the information. Regarding the innovation in early diagnosis and cancer care, AJ noted the clear requirement in the guidance and an allocation of funds to support innovation programmes for early diagnosis. The bids process for this funding has been live since late April and so far, there have been 56 proposals. Currently the proposals are being scored and evaluated with the hope that ideas can be pulled out from across the GM system. AJ noted the improvement in the % of lower GI referrals with FIT results included, with the current figures already hitting the Q2 target. She commented on the positive feedback from the work with AP and her team on public and patient facing communication and noted that funding had also been allocated to localities in a controlled manner to use on engagement activities, events, and programmes. Regarding GP Direct Access Diagnostics (DAD), AJ confirmed there was only a little information in the planning guidance on this, but the focus has stepped up in last few weeks, ST and AJ are linking in with Northwest and Primary Care colleagues in GM to discuss development in areas that don't

	have GP DAD, including Brain MRI, and Direct Access CT. The work focuses on promoting to GPs how to use systems and the 2-week wait referral forms. RS reported he chaired the National Cancer Boards group on early diagnosis and noted that for 10 years the percentage for early diagnosis had been consistently stable at 53% but it has shifted. Since the pandemic there is a new trend which brings forward a requirement to learn what the connection is between interventions and this improvement. The Targeted Lung Health Checks (TLHC) work is credited in part for the improvement and made the connection between registration and the trend that rapid registration shows is congruent with gold standard registration. The downsides were also noted, such as variation across tumour sites on early diagnosis, deterioration on colorectal pathways and deterioration in the equalities gap in pathways. There is a significant improvement in the use of the Faecal Immunochemical Stool (FIT) tests. ST noted that the colorectal figures will be changed by the increased implementation of FIT tests as makes a referral so much easier to process. It was noted that there was interest nationally in the results from the NHS Galleri trial. AA give info on NHS Galleri trial, with a staging post coming up shortly, interventions will have exposure and any positive changes will be noted. AA noted that the first results will be available in 2025. RS confirmed a requirement for the board to keep up to date on this. JP commented that insight work has just been commissioned into immunisation fatigue and cancer screening programmes which will help target approaches and information. RS explained that he will hear more on a national screening level as there is work to move these things forward in digital. Some programmes and pathways need modernising and there is a need to put a focus on what happens nationally and where the responsibility lies. He commented that another topic for discussion is the risk on stratified screening which has been a political clinical tension with experts. DS reported that there is potential in this space as it is about people with symptoms and looking at this data, he wondered if there is a tool that complements symptoms and could help to refer.
Actions and responsibility	AJ to provide a link to Tableau for the Rapid Cancer Registration Data to be circulated after the meeting.

7. Locality Visit Report	
Discussion summary	AJ referred to the paper circulated before the meeting on the locality visits which started in September 2022 and finished in March 2023. Localities were encouraged to bring Primary and Secondary care staff and the meetings were attended with several members of the GM Cancer Alliance Senior Management Team. The discussions were broad which went down well with a positive response. The paper notes a summary of the discussion topics. AJ requested that the board support the alliance to repeat the process due to the positive feedback received. A visit has been organised to The Christie in the same vein to understand their work programmes and priorities. RS observed that this is an approach on how to move forward with either a system or locality and to check what is required with maximum impact.

	SP supported the idea and noted that it gave an opportunity for those in Secondary care to see what is happening in Primary care. There is a high level of shared learning and value in these visits. AJ noted that these visits were better face to face rather than online. COR noted that there were problems and solutions noted at all visits and the task is to pull them together. The locality visits show solutions to system-wide problems and while doing this in cancer, there are places for it to be explore in other systems.
Actions and responsibility	Nil of note

7. Health Inequalities Strategy	
Discussion summary	DC introduced the refreshed Health Inequalities Strategy and explained that work started before the first workshop in September 2022, with a working group commencing in April 2021. DC started in post just in time to create the new strategy with an aim to 'tackle inequalities in cancer incidence and outcomes and improve equity in access and experience of cancer care'. DC referred to the new structure noted in the paper, which came about due to the size of the working group becoming too large. There is now a smaller programme board with a strategy and implementation plan and further Task and Finish groups. He noted a piece of work done at the GMCVO which developed principles and worked with the Population Health team to align strategies. He referred to these principles which he included in his slides. DC added that the needle will only be moved if Health Inequalities become everyone's business, so it needs to be in all programmes. Regarding Early Diagnosis and access to healthcare and cancer screening, the team will act on equality in case finding and understanding the inequalities in accessing diagnostics. There is interesting data coming forward on diagnostics which will help the system to see where in equalities exist. DC explained that the next step in implementation is the live piece that is developed by programme boards, on which he will report back to the board as much as required RS noted that a general understanding of the space is useful for all board members and an infographic may be useful for this topic. RS noted he would like to understand the system-wide point of view. JP explained that a couple of her team are joining the Health Inequalities Programme board and there are key opportunities around how data is used in a more sophisticated way. She noted the need to understand the populations they trying to serve. She then referred to an initiative in the research and development space headed by Manchester University who are developing a Healthier Futures institute offering solution focused research to which they are brining resource in. The challenge for the integrated care system is how to allocate resource and attempting different approaches. DC referred to the data and noted that the BI team is working on data regarding inequalities in access and process, and inequalities in outcomes. There are challenges in the Rapid Cancer Registrations data set regarding the secure environment with a referral dashboard being tested, looking at the intersectionality of the people which can be seen on the map and use tools to see pockets of people who aren't being referred. JP commented that the City of Manchester had done amazing things now they are able to join the primary care data up with theirs. They have been able align the quantitative data with insight data.

	DS remarked on the focus on evidence-based interventions noting examples such as the TLHC taking place in the most deprived areas first. He noted the work being done by RB on inequalities, with cancer treatment figures based mainly on Caucasian patients. There are different treatments required for patients with different ethnicities who also show cancer differently. DS noted it would be good to have RB present on this work at a future board meeting. DC noted his relationship with the Manchester Cancer Research Centre (MCRC) and allowing them access to secure data environment. This allows them to test which research can be done with the data and launch health inequalities research in a supported environment. The other piece in GM is targeted with deprivation as a stratification for delivery, which is important for case-finding in other alliance projects. RS confirmed the importance of communicating widely around interventions otherwise there is a risk of an inequalities gap. DC noted work happening across the NHS's research infrastructure in the National Institute for Health and Care Research (NIHR) space. He noted the importance of making a connection with those who have worked on engagement of underserved communities what has Manchester won the hosting for.
Actions and responsibility	RB to present on his work on inequalities at a future GM Cancer Board meeting.

8. Papers for Information	
Discussion summary	RS went through the papers for information. AA noted that the draft of the Planning Guidance Return was issued in March. There were only some minor tweaks to amend and final sign off should be received this month with the funding agreement sent shortly. Regarding the Finance Return, there were no surprises. There was a 1.5% variance for 2022/23 which was not a concern.
Actions and responsibility	Nil of note

8. AOB	
Discussion summary	Due to timing limitations, there was no call for AOB. RS thanked everyone for their attendance and participation.
Actions and responsibility	Nil of note

The next meeting is scheduled Monday 17th July, 15.00 – 17.00 at
The LifeCentre, 235 Washway Road, Sale, M33 4BP

Action Log

Prepared for the 15th May 2023 GM Cancer Board.

Log No.	AGREED ON	ACTION	STATUS
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
05.23	May 2023	An update on the GM ICB System Review to be brought back to next GM Cancer Board meeting.	Ongoing
05.23	May 2023	AJ to provide a link to Tableau for the Rapid Cancer Registration Data to be circulated after the meeting.	Complete
05.23	May 2023	RB to present on his work on inequalities at a future GM Cancer Board meeting.	Ongoing

GM Cancer Board

15th May 2023

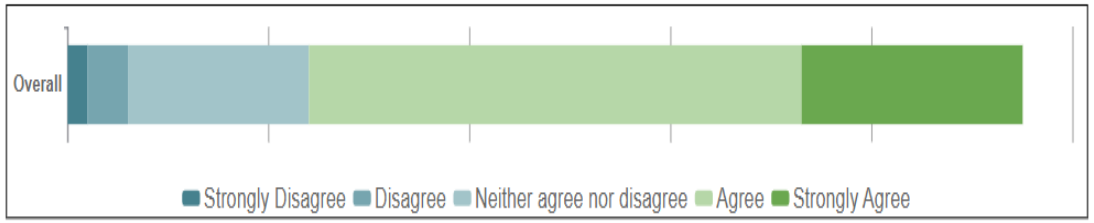
Cancer Workforce and Education Strategy

Suzanne Lilley, Programme Director for Workforce and Education

15th May 2023

Cancer Workforce and Education Strategy

1. System engagement



2. Strategy – At a glance

STRATEGIC PRIORITIES

Workforce Integration	Workforce Wellbeing	Growing and Developing our Workforce	Addressing Inequalities
• One cancer workforce ambition • Improve integration across the sectors through blended roles and equity in access to education • Pilot cancer fellows • Scale and spread new roles that have been piloted • Promote the use of the Digital Staff Passport • Explore digital solutions to enable greater connectivity across the system	• Promote current wellbeing offers • Work with the People and Culture function to measure the uptake and impact of current wellbeing offers specifically within the cancer workforce • Promote a lifelong learning culture through The GM Cancer Academy and Education Collaborative	• Promotional campaigns to raise the profile of careers in cancer • Support implementation of the ACCEND framework at a local level • Build on national preceptorship and legacy mentoring programmes for the specialist workforce • Development packages for all clinical and non-clinical staff • Work with VWIS to collate system wide cancer workforce data	• Increasing diversity within the cancer workforce • GM Cancer Workforce Health Messaging • Tackling Inequalities Training • Ensure equity in access to education through the GM Cancer Academy as a single point of access for all cancer education

Cross Cutting Activities

GM Cancer Academy - cancer education hub for GM to support our lifelong learning ambition

National ACCEND Programme - National Career and Education Framework for the non-medical workforce.

3. Next steps

Wider dissemination

Discussion with HRDs May 16th

Sign off by GM Cancer Board May 15th

Questions?

Faster Diagnosis, Operational Performance and Treatment Variation

Lisa Galligan-Dawson
Director of Performance

Operational Performance

CURRENT PERFORMANCE

FDS

Feb -72.8%
Trajectory
73.98%

FDS delivered at GM level in Breast, Breast Symptomatic, Haematology, Lung, Sarcoma and Skin

BACKLOG

Mar -820
Trajectory –
668

Significant improvement across provider, with four Trusts delivering their plan

IMPROVEMENT FOCUS

- Targeted
- Matched with key challenges
- Governance
- Sustainable

PATHWAY

NATIONAL

Breast
Skin
Prostate
LGI

LOCAL

Gynaecology
Bladder
Lung

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

patient to Sir Mike Richards 2018

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.

- Personalised Care Improvement Facilitators previously provided training – re-invigorating roles (jointly with ICB Person & Community Centred Care Programme) to support visibility and be an advocate and champion within Trusts.

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
  - Utilising nationally developed OPA deployment estimator tool for key PSFU groups by Trust to understand potential impact (supporting NHS LTP to reduce f2f appts by a third)
- 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
  - Education = cancer academy (personalised care specific sub logo developed)
  - Protocols/pathways/resources/shared learning = NHS futures page for GM
- 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.

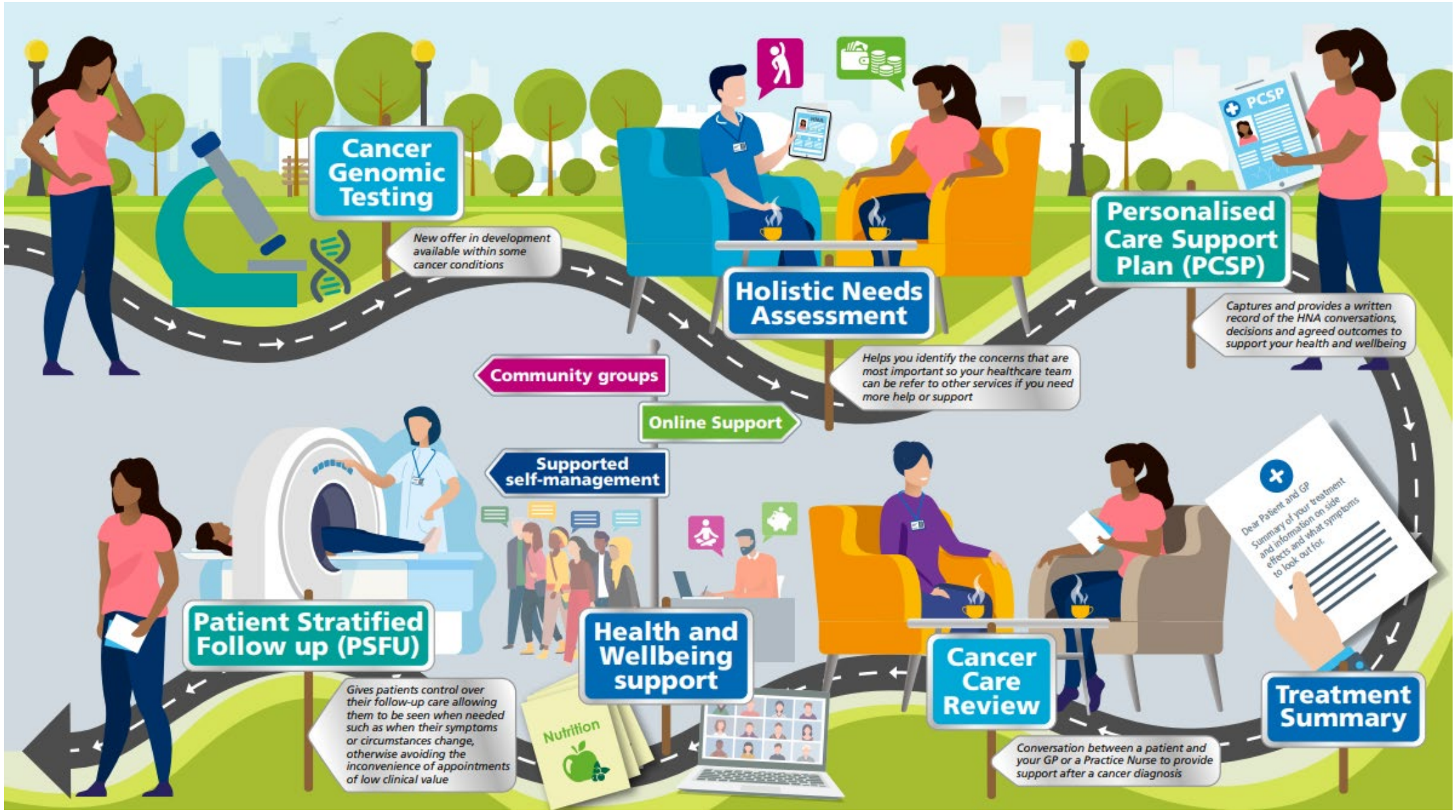
- Audit produced and shared with Trust PC leads to complete with CNS teams – will inform 23/24 rollout plan for PSFU by Trust (GM developed definition of 'fully operational' in line with National handbook)
- Alliance will then co-ordinate staff training/engagement events to support clinical teams – recorded infoflex 'show & tell' sessions available for Trusts to use and share with colleagues

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 – 60+ responses so far
- LWWC Programme Manager started in post 1st May

Greater Manchester Cancer

What is personalised care – a patient pathway



Greater Manchester Cancer

Early Cancer Diagnosis

Ali Jones
Director of Commissioning
& Early Diagnosis
15th May 2023

Highlights / Update – Early Diagnosis

Rapid Cancer Registration Data – on Tableau to Q4 2022-24 by tumour site and provider

	FY 2019 - 2020				FY 2020 - 2021				FY 2021 - 2022				FY 2022 - 2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Grand Total	54.8% (n=2,766)	54.1% (n=2,703)	53.6% (n=2,670)	54.7% (n=2,772)	53.3% (n=2,342)	48.3% (n=1,634)	49.8% (n=2,167)	51.9% (n=2,239)	54.3% (n=2,544)	52.5% (n=2,471)	52.4% (n=2,616)	55.6% (n=2,623)	55.9% (n=544)	55.6% (n=2,653)	57.6% (n=2,616)	55.2% (n=2,147)

Primary **care education:** Cancer Forum held 18th April – Homelessness, lung cancer in non-smokers, prostate, FIT, children's cancers. PCN cancer leads sessions and bulletin delivered April 2023 and agreement to continue into 2023-24

Innovation in early diagnosis and cancer care 2023-24 supported by Cancer Alliance funding – Expression of Interest process launched late April – in progress (timetable and process in place to review EOIs and follow up with detailed business case requests)

Significant improvement in the % of lower GI referrals sent with **FIT** result included – 22.1% April 2022, 65.8% February 2023 and **70% in March 2023**

Prostate Cancer Case Finding project launched 2nd May 2023 – 'This Van Can'. Very positive response and all appointments booked

Continued delivery of patient and public facing communication to promote uptake of screening programmes and early presentation with symptoms. Allocation to localities for engagement and locality delivery

GP Direct Access Diagnostics - **Increased profile for this piece of work – engagement with GM Primary Care System Board and NW Diagnostics lead**

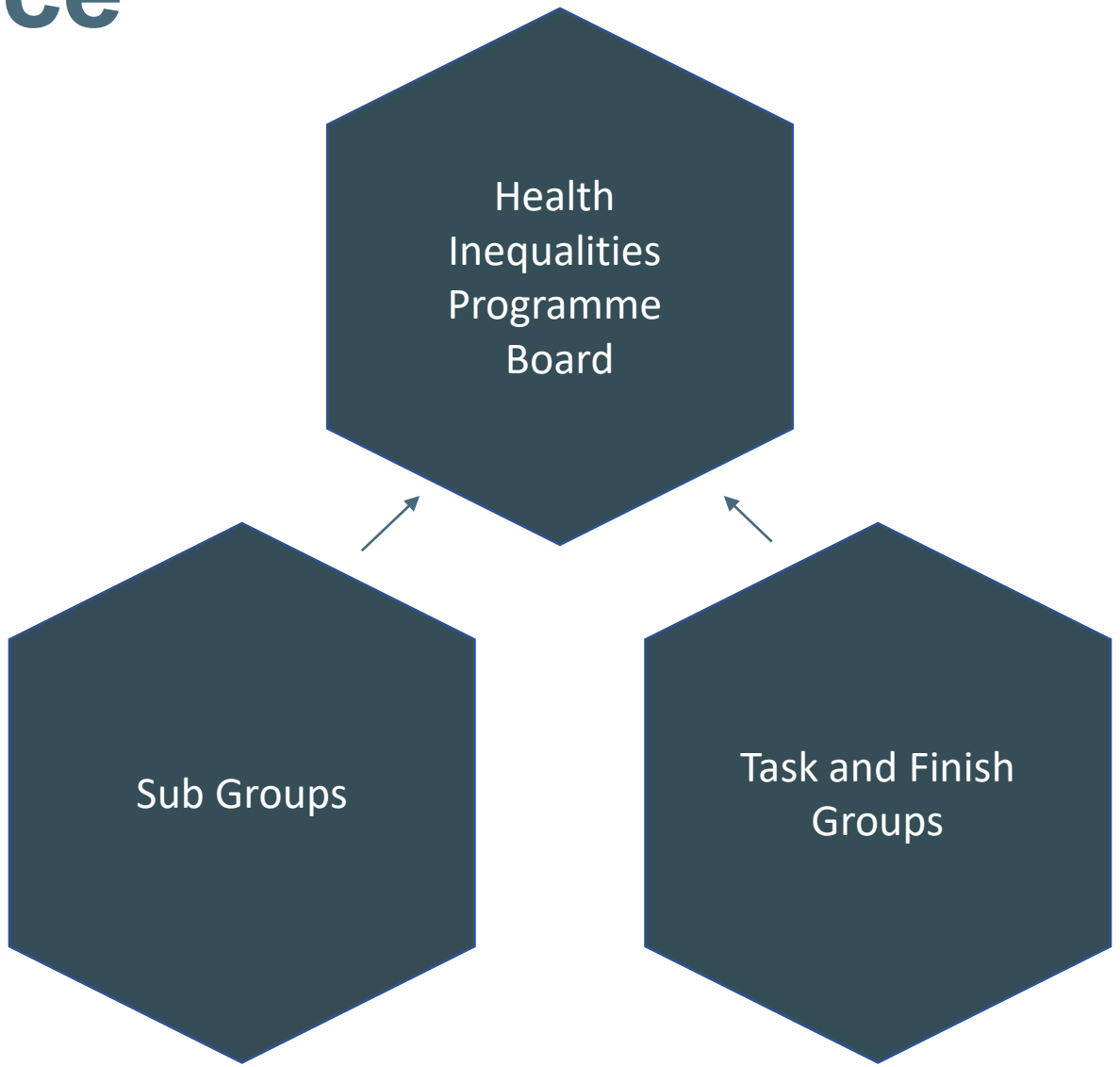
Locality Visit Report

Ali Jones
Director of Commissioning
& Early Diagnosis
15th May 2023

Greater Manchester Tackling Inequalities in Cancer Strategy

We will tackle inequalities in cancer incidence and outcomes and improve equity in access and experience of cancer care

Governance


Health Inequalities Programme Board
Sub Groups
Task and Finish Groups

Principles

This strategy supports the principles as set out in the Greater Manchester ICP Strategy to reduce inequalities, which also incorporate those set out by the GMCVO report:

People Power

We will work with people and communities, and listen to all voices including people who often get left out. We will build trust and collaboration and recognise that not all people have had equal life opportunities.

Proportionate Universalism

We will co-design universal services but with a scale and intensity that is proportionate to levels of need.

Health Inequalities are everyone's business

We will think about inclusion and equality of outcome in everything that we do and how we do it. Developing an institutional habit of thinking inclusively enables us to go beyond the minimum requirements of legislation and service standards, and supports universal design, creativity and innovation.

Representation

The mix of people who work in our organisations will be similar to the people we provide services for.

Health Creating Places

As anchor institutions we will build on the strengths of our communities and leverage collective power – to support communities and local economies.

Risk Reduction

We will work with partners to reduce the inequalities in prevalence of behavioural risk for cancer and tackle inequalities in access and outcomes to preventative programmes.	
We will influence… • the wider programmes of work in GM that are addressing the wider social and commercial determinants of health (i.e. air quality, housing quality, good employment etc) • support delivery of the Greater Manchester ICP Strategy and coordinated work across the system to reduce inequalities across the life course to create a greener, fairer, and more prosperous city-region • GM prevention programmes such Make Smoking History and support them	We will… • reduce inequalities in access HPV Vaccination • amplify and support local, regional, and national prevention campaigns, ensuring they reach the right communities • implement upstream models of care within cancer pathways, ensuring they are preventative, person-centred, integrated

Early Diagnosis

We will work to improve equitable access to healthcare and cancer screening and reduce inequalities in signs and symptom knowledge.	
We will influence… • the wider primary care sector to reduce the inequalities in access to seeking help • support the wider system to be more aware of cancer signs and symptoms including those working with and supporting health inclusion groups	We will… • reduce inequalities in access, experience and outcomes of the three cancer screening programmes • support any innovations in case finding to ensure they are targeted to the most need • amplify and support national signs and symptoms awareness

Diagnosis Treatment and Care

We will work to tackle inequalities in access and experience of diagnosis, treatment, and care.	
We will influence… • our partners to record, analyse and take action, on a trust level, on performance differences in patient cohorts • our partners to ensure innovations in diagnosis, treatment and care are focussed on tackling existing	We will… • undertake work to better understand the health inequalities that exist in time to diagnosis • target inequalities in treatment as identified through the pathway boards • lead work on patient empowerment and person centre care • ensure cancer services are accessible to all, including services, information and support • ensure personalised care in GM is both universal and targeted to those that need it most

Research

We will work to tackle inequalities in access and experience of diagnosis, treatment, and care.	
We will influence… • and support the research community in GM to increase funding into Health Inequalities focussed research projects	We will… • seek to understand the health inequalities that exist in research in GM • act to increase access to clinical trials for those that are currently underrepresented • scope the inequity in research nurse represent

Workforce

We will work collaboratively with key stakeholders to promote 'Belonging to the NHS' focusing on inclusion and reducing inequalities within the cancer workforce.	
We will influence… • the cancer system to recognise the importance of workforce EDI by ensuring that inequalities is a cross cutting theme across all activity within the Workforce & Education Strategy	We will… • work with key stakeholders to understand the current cancer workforce demographic and increase workforce representation through inclusive recruitment practices • increase staff confidence through upskilling education packages • advocate for our workforce to prioritise their health and wellbeing to live well

GM Cancer Alliance

We will ensure everything we do at the Greater Manchester Cancer Alliance supports the reduction in health inequalities across the cancer system in Greater Manchester.	
We will influence… • others in GM and there work on inequalities to support the work we are doing in Cancer, including the ICB, Population Health and the VCSE sector • influence others to capture data in a way that makes it useable	We will do… • meet all health inequalities asks as to set out in the cancer planning pack • develop a Health Inequality data dashboard • ensure all projects have reducing health inequalities as a core principle and monitored through the Equality Impact Assessment process. • develop a representative user

Next steps…

Their will be an implementation plan developed as part of this strategy that will:

- be developed by the Health Inequalities Programme Board, Cancer Alliance and wider cancer system
- be monitored through the Health Inequalities Programme Board
- will detail ‘how’ the objective detailed in the strategy will be delivered
- Will be a live document with projects and programmes being added as approved by the Health inequalities Board that meet the objectives of the strategy

Papers for Information

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

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

Cancer board Paper, 15th May 2023

Title of paper:	Cancer Workforce and Education Strategy
Purpose of the paper:	To request support for the refreshed Cancer Workforce and Education Strategy
Summary outline of main points / highlights / issues	With the creation of the NHS Greater Manchester Integrated Care and Greater Manchester Integrated Care Partnership, the Cancer Workforce and Education strategy has been updated to align with the refreshed Greater Manchester People and Culture strategy and recent planning guidance.
Consulted	• Greater Manchester People Board • Cancer Alliance Senior Management Team • GM Cancer Workforce and Education Board • Wide variety of stakeholders across the system including (but not limited to) HR Directors, Directors of Strategy, Clinicians / Workforce Leads / Directors of Workforce from across all sectors, and patient representatives.
Author of paper and contact details	**Name:** Suzanne Lilley **Title:** Programme Director for Workforce and Education **Email:** suzanne.lilley2@nhs.net

1 Background and Context

The full strategy including how this was developed can be found below. Please note once this receives support from the board, the document will be designed and co-branded to align with both the Greater Manchester Cancer Alliance and Greater Manchester People and Culture Strategies.

2 Next steps

The strategy will be socialised across GM networks and further discussions will be had specifically with HR Directors and locality Deputy / Place Based Leads to encourage alignment were possible with local / organisational workforce strategies, to enable implementation.

3 Recommendation, requests / support required of the Board

The Greater Manchester Cancer Board is asked to:

- Support the refreshed Cancer Workforce and Education Strategy before wider dissemination.

Greater Manchester Cancer Alliance

Cancer Workforce and Education Strategy

Strategy Content

1. Introduction

Demand for cancer services increases year on year and the growth of the cancer workforce is not keeping pace with this increasing demand. This challenge was exacerbated by the pandemic and remains the biggest barrier to recovering cancer services and improving the way we provide health and care in our communities.

The first Greater Manchester (GM) Cancer Workforce Strategy was developed in 2020/21 to support the National Cancer Workforce plan, National People plan and Greater Manchester's Covid response and recovery plans. The GM Cancer Alliance Workforce and Education Team led the delivery of the strategy in collaboration with profession-specific workforce groups however, with the creation of the NHS Greater Manchester Integrated Care and Greater Manchester Integrated Care Partnership, the strategy has been updated to align with the refreshed Greater Manchester People and Culture strategy.

The Greater Manchester Cancer Workforce and Education strategy is not to be taken in isolation, there will also be a separate albeit interlinked Greater Manchester Education Strategy to support our lifelong learning ambition for the Cancer Workforce, a GM Cancer Digital and Innovation strategy, to support workforce digitisation, and a GM Cancer Tackling Health Inequalities strategy to ensure workforce equality, diversity and inclusion is prioritised throughout.

The new strategy will not include activities specific to Diagnostics or Radiotherapy workforce groups due to there being separate complementary system-wide strategies covering these professional groups, see below (list is not exhaustive):

- Northwest Imaging Workforce Strategy

- GM Endoscopy Workforce Strategy (in development)

- GM Pathology Workforce Strategy

- Northwest Radiotherapy Workforce strategy (in development)

The GM Cancer Workforce and Education team maintains links with the various diagnostics workforce groups and Operational Delivery Networks (ODN), including Radiotherapy, Teenage and Young Adults, and Children, to support them with their work and ensure cancer remains high on the agenda.

2. Our Strategy

Our ambition

To develop and grow the cancer workforce in Greater Manchester to ensure the workforce is representative, inclusive, and supported to respond to the needs of people affected by cancer, by adapting to new, improved ways of working, and embrace innovation and technology to deliver the best quality healthcare

This Cancer Workforce Strategy sets out a shared ambition for our people in Greater Manchester; will align and support organisational and locality workforce plans were possible and support the delivery of the NHS People Plan, the Greater Manchester People and Culture Strategy, and Greater Manchester Cancer Plan.

The strategy provides a framework for:

- delivering a one workforce ambition *(see appendix 1 for all professional groups supported by the activity in the strategy)*
- delivering a range of initiatives / innovations / solutions / interventions to be developed and implemented at system level
- practical and deliverable long-term solutions to ensure GM has the right workforce in place to meet the needs of people affected by cancer
- enabling sustainable and agile cancer workforce solutions to grow skilled practitioners responsive to changes in healthcare requirements, technological developments, new ways of working and new roles.

It does not replace the need for organisation level workforce plans instead, it provides a set of priorities that stakeholders agree are best addressed in a coordinated way at the GM system level to complement locality plans.

The strategy will be reviewed annually to ensure that it remains agile and responsive to changes in policy, development of new inter-dependent strategies, opportunities arise, and new challenges emerge.

Development of the strategy so far

The strategic activity has been coproduced with key stakeholders including Patient and Public Involvement and Engagement (PPIE) representatives.

3. Strategic drivers

4. Programme Alignment

GM People and Culture Priorities	GM Cancer Programmes of Work
Workforce Integration	Early diagnosis and prevention
Workforce Wellbeing	Personalised care and treatment
Addressing Inequalities	Identifying and addressing Inequalities
Growing and Developing our Workforce	Operational Delivery and Faster Diagnosis
Good Employment*	Research

**There is currently no separate section for Good Employment however, the workforce inequalities programme includes activity that aligns with the People and Culture strategy: Good employment section e.g. promoting inclusive recruitment and sharing best practice and resources.*

5. Cancer Workforce Strategy 2021 – activity delivered / progressing

Workforce Wellbeing	Workforce Integration	Addressing Inequalities	Growing and Developing our workforce
Dedicated GM Cancer webpage launched with a Workforce section. All relevant health and wellbeing resources are signposted to from this page.	Boundary spanning pilots in progress: i) 9 Primary Care Networks (PCN) are currently piloting the role of the Cancer Support Worker to provide seamless personalised care for patients ii) Collaboration between Oldham Primary Care Network (PCN) and Salford FT to pilot the role of the Physician Associate as a blended role split between working in primary care and within the urology service at Salford FT.	Establishment of the GM Cancer Workforce & Education EDI Working Group with co-developed work programme. Two Lead cancer nurses secured a place on the 'Race Equality Change Agents Programme' (RECAP) led by the GM ICS - projects ongoing.	**Attract** -Led the first National Cancer CNS Day to raise the profile of the CNS role within the general nursing workforce in 2022 -Aspiring CNS programme pilot project to attract general nurses to cancer, currently being evaluated. **Recruit** -Physician Associate role piloted across 9 cancer pathways; evaluation available for the initial urology pilot. -9 CCCs recruited in PCNs **Develop/ Retain** - NW Allied Health Professional (AHP) survey was conducted to identify training gaps -Bespoke Cancer AHP Training Programme (Allies in Cancer Care) has been developed and launched in response to NW AHP Survey findings - Bespoke training webinars hosted for Cancer Support Workers - e-Learning module for MDT coordinators currently in development - Supporting the development of four National Acute Oncology Competency Passports - Making Every Contact Count (MECC) for cancer programme piloted - GM Cancer Support Worker forum established to offer peer to peer support and a platform to share and learn / promote integrated working - MDT leadership training programme pilot.

6. Cross cutting workstreams delivered / in progress

NHSE Digital Staff Passport piloted across 4 different professional groups (ACPs, Surgeon, CNS', Radiologists) to enable movement of staff. Case studies and report available.

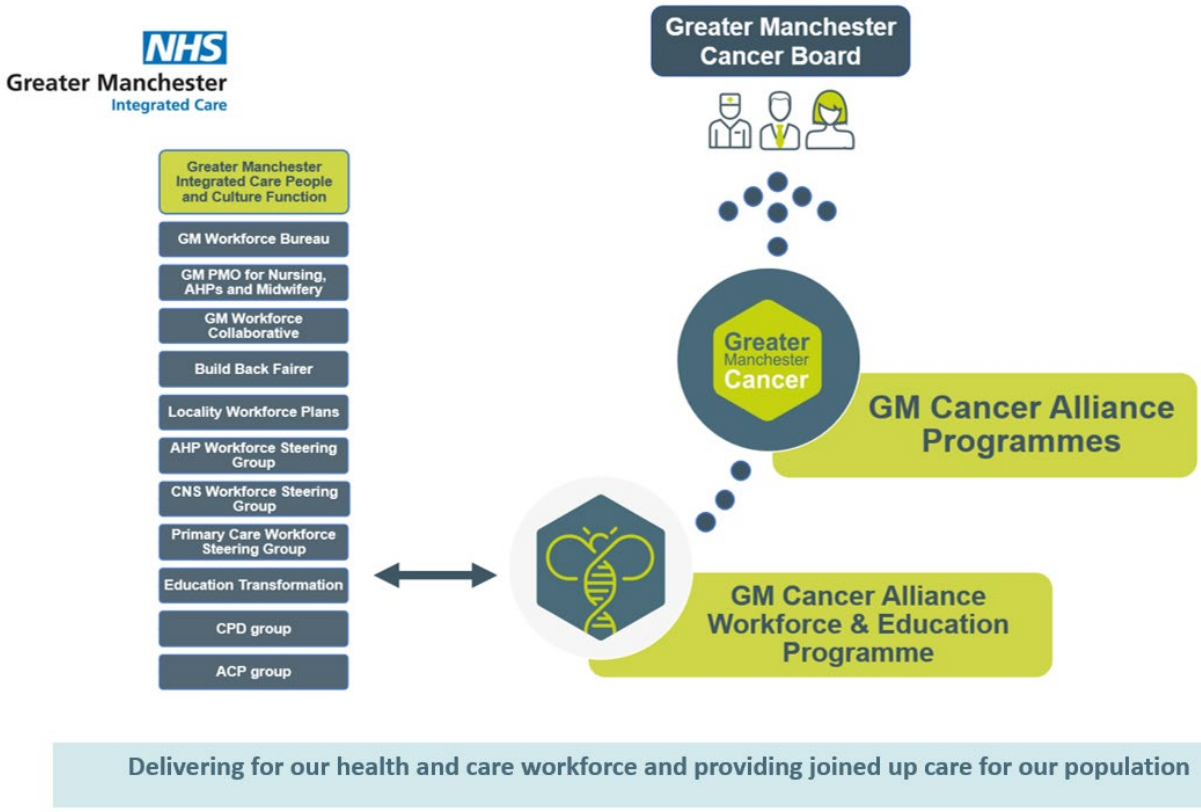
Cancer academy launched as the cancer education hub for GM to support our lifelong learning ambition.

Diagnostics workforce review - Imaging and Endoscopy qualitative workforce reviews conducted to inform future workforce models. Recommendations being taken forward by the networks.

ACCEND - the National ACCEND programme consists of a National Career and Education Framework for the non-medical workforce to support recruitment and retention. GM Cancer leading the workstream for specialist nurses and AHPs

7. Future Plans for 2023-2025

The following section details activity that will be delivered over the next 12 months and beyond. The workforce and education team will work in collaboration with the ICP People and Culture function, system partners, and locality teams to support delivery at a system level.



7.1 Workforce integration

1 in 2 people are predicted to receive a diagnosis of cancer within their lifetime and so there is a need to upskill the whole of the health and care workforce to ensure Greater Manchester achieves the long-term plan ambition of earlier diagnosis and personalised care for cancer patients.

To achieve this one cancer workforce ambition and support the workforce to work both horizontally across place and vertically across the different sectors, the following activity will be prioritised:

- Promote the use / integration of the various digital solutions currently on offer to enable the cancer workforce to move around the system:
    - National NHSE Digital Staff Passport
    - Cancer Academy e-portfolio
    - Primary care and social care passports

- Explore digital solutions to enable greater connectivity across the system to provide communities of practice, promote peer to peer support / sharing of best practice.

- Provide a mutually beneficial model for cross system working bringing together generalist and specialist roles, including mentoring and coaching.

- Explore the role of a neighbourhood cancer lead in line with the People and Culture strategy to work within the community as part of health and wellbeing services.

- Pilot and evaluate blended roles in cancer care, including blended clinical and operational roles.

- Pilot Cancer fellowship programmes across primary and secondary care:
    - link in with the Primary Care GP and Nurse Fellowship programmes to support early diagnosis, education, and personalised care for cancer patients,
    - explore fellowship programmes for the medical workforce.

- Build on existing new roles that have been piloted, to expand to other professional groups or to scale and spread across the system:
    - Physician Associates in Cancer
    - Primary care extended roles / specialist interest in cancer
    - Cancer Care Coordinator pilot in Primary Care Networks.

- Explore innovative / integrated workforce solutions to support the delivery of:
    - Best Practice Timed Pathways (BPTP) in order to achieve the Faster Diagnosis Standard
    - Seamless personalised care for cancer patients.

- Support the provision of integrated education available to all sectors through the Education Collaborative, including the development of bespoke early diagnosis development packages for all health and care staff.

- Expand the Cancer Academy skills lab programme to support staff working across different sectors to support cancer patients including Social Care, and Mental Health professionals.

- Rollout non-medical referral training for Practice Nurses and other professional groups where appropriate.

- Use the learning from global workforce initiatives to support better integration.

7.2 Workforce Wellbeing

The pandemic has had a significant impact on the health and wellbeing of our workforce and is a key factor influencing individuals' decisions to stay. There is a plethora of resources available at an organisation / system level and so the role of the alliance is to promote these resources, promote cancer education offers to the cancer workforce to ensure equity in access, and to identify any gaps.

- Promote existing health and wellbeing offers to the cancer workforce through a dedicated directory on the GM Cancer website e.g. the ICB wellbeing toolkit

- Share good practice across the system and identify any gaps for specific professional groups

- Work with the ICB People and Culture Function to measure the uptake and impact of current wellbeing offers specifically within the cancer workforce

- Utilise and expand Cancer Workforce Days to provide an opportunity to celebrate the workforce, promote joint identity, and ensure the workforce feel valued

- Ensure equity in access to cancer education through the GM Cancer Academy

- Promote a lifelong learning culture through The GM Cancer Academy and Education Collaborative by influencing the system to ensure all health and care staff have protected time for education and training

- Promote the NHSE Digital Staff Passport as a tool to support personal development and working as a network

- Promote flexible working resources / toolkits to support sustainability and work life balance

- Explore current offers to support staff who are carers, to promote their wellbeing and ensure their needs are being met.

7.3 Growing and Developing our Workforce

Growing the workforce to keep pace with the growing demand for cancer services is essential to addressing the cancer workforce crisis, however, ensuring the current workforce has opportunities for personal development is equally as important if we want people to stay. The following priorities will help to:

Attract new health and care staff through innovative ways	Recruit more people into cancer by developing clear routes into professions and opportunities for generalist roles
Retain the cancer workforce by providing support / mentorship, investing in education and providing opportunities for lifelong learning.	

7.3.1 **Attract new health and care staff through innovative ways**

- Work with other professional groups to support promotional campaigns to raise the profile of careers in cancer

- Make links with GM Access and Step ahead programmes to promote future careers in cancer

- Link in with education providers (Higher Education Institutes, Colleges, and Schools) to:
    - Raise the profile of a career in cancer

  - Building on the digital clinical placement expansion programme, establish cancer placement pathways for student nurses and AHPs, as part of the Targeted Practice Education Programme
  - Influence curriculum development.

- Explore the use of the digital placement model and digital staff passport to expand post registration placement opportunities across GM

- Pilot pathways for cancer volunteers / carers interested in a career in cancer, supported by a training package

- Optimise use of the apprenticeship levy to support routes into the cancer workforce

- Promote using the ACCEND framework to support the development of generalists who have an interest in a career in cancer

- Explore pathways for staff groups to transition into new roles within screening supported by clearly defined training routes

- Evaluate and expand the Aspiring CNS programme to attract general nurses into a career in cancer and link outcomes to the ACCEND programme

- Explore the development of additional 'Aspiring' Cancer Clinical pathways.

7.3.2 **Recruit more people into cancer by developing clear routes into professions and opportunities for generalist roles**

- Promote using the ACCEND framework to inform / standardise job descriptions for the non-medical workforce

- Promote and coordinate the ACCEND training programmes to upskill aspiring cancer support workers / nurses / AHPs to support future recruitment

- Promote inclusive recruitment through the workforce EDI programme

- Promote ICP offers related to good employment

- Targeted project to scope and promote the role of the Advanced Clinical Practitioner in cancer

- Utilise the NHSE Digital Staff Passport to support recruiting staff to rotational roles where a need has been identified.

7.3.3 **Retain the cancer workforce by providing support / mentorship, investing in education, and providing opportunities for lifelong learning.**

- Align with the GM Retention Strategy and support planned activity led by the ICP

- Collaborate with the GM NHS Integrated Care Virtual Workforce Information System (VWIS) team to collate system wide cancer workforce data, including retention data, surgical audit, and Medical & Clinical Oncology workforce review.

- Conduct a gap analysis for research nurses to understand recruitment and retention issues, overlaid with research offer and patient uptake

- Support implementation of the ACCEND capability framework to promote retention through continuous professional development

- In alignment with ACCEND, support the implementation of the National Acute Oncology competency passports to upskill all relevant workforce groups working across primary and secondary care

- Building on the national Preceptorship and Legacy mentoring programmes, pilot an approach to retaining the cancer workforce throughout their career trajectory

- Work with pathway boards to pilot an approach to defining safe caseloads for the CNS' workforce including a review of current skill mix models, to inform workforce modelling

- Expand the GM Cancer Academy - the cancer education hub – to ensure it acts as a single point of access for all cancer education

- Establish a Cancer Academy Faculty of subject matter experts to support the development and delivery of education

- Support the delivery and sustainability of the Allies in Cancer Care AHP Cancer Training Programme and link this to the ACCEND Programme

- Support workforce digitisation including access to online education and development through the Cancer Academy

- Ensure equity in access to genomics education for the cancer workforce via the cancer academy

- Support the wider rollout of Prehab and rehab through the cancer academy

- Build links with the GM Practice Educator Centre for Excellence to support the expansion of Practice Educators in cancer to ensure equitable access to training and education to improve standardisation of practice

- Conduct a needs analysis to understand training needs of our senior leaders and future leaders

- Explore a leadership development package to support Pathway Board members in their system role

- Create development packages for the non-clinical workforce e.g. Cancer Trackers, Cancer Managers etc.

7.3.4 **Cross cutting workstreams**

- In line with organization's social responsibility commitment, promote the importance of protected time within job plans for all to:

    - Complete training and education as part of their continuous professional development
    - Enable learning and practice across the four pillars of practice in line with the ACCEND framework

- Reduce inequity in access to level 3 Psycho-Oncology supervision

8 Addressing Inequalities

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

The GM Cancer Alliance Workforce and Education Team has established a system-wide Cancer Workforce Inequalities Working Group, which will work collaboratively with the ICB Health Equity Team, feeds directly into the GM Cancer Health Inequalities Board as an active subgroup and forms part of the GM Cancer Tackling Health Inequalities Strategy.

Inequalities will be a cross cutting theme across all strategic activity, supported through a programme Equality Impact Assessment (EIA) in addition to project specific EIAs. There will also be a dedicated EDI workforce programme, which we anticipate will evolve significantly during the next 12 months as the ICP EDI function matures. Initial activity includes:

8.1 **Increasing diversity within the cancer workforce**

- Work with the GM VWIS Team to understand current workforce race equality data as part of the workforce data pilot
- Pilot race equality interventions to increase representation of the cancer workforce to:
    - Ensure the workforce is representative of the community that it serves
    - Promote the good employment charter interventions supported by the ICB
    - Inform future recruitment practices

- Promote inclusive recruitment practices utilising learning from previous projects outside of cancer

- Signpost and promote ICP recruitment guides to cancer workforce recruitment colleagues to ensure fair and equitable chances of success, and exploration of alternative entry routes to attract diverse talent

- Work with pathway boards to ensure diverse and inclusive representation from the different professional groups.

8.2 GM Cancer Workforce Health Messaging

Work in collaboration with key partners and the GM Cancer Early Diagnosis programme to promote and encourage the cancer workforce to live well and engage with health promotion campaigns / programmes, including but not limited to:

- Make Smoking History
- Making Every Contact Count (MECC) for Menopause
- Cancer Screening Campaigns

8.3 Tackling Inequalities Training

- In collaboration with the LGBT Foundation develop a training module to enable the cancer workforce to have mutually empowering conversations with patients and ask inclusive questions

- Support and expand the ConnectEDcare Project to ensure equitable access to EDI training

- Work in collaboration with the Cancer Academy to develop a training package; *Understanding and Supporting the role of the Carer*, to enable staff to support carers and their wellbeing.

GM Cancer Board

Monday 15 May 2023

Title of paper:	Faster Diagnosis Standard (FDS), Operational Performance (OP) and Treatment Variation (TV) Programme Update
Purpose of the paper:	To advise the GM Cancer Board of the current performance against the planning objectives associated with this work programme along with the latest cancer waiting times (CWT) performance
Summary outline of main points / highlights / issues	• Year end backlog position, 820 against the planning trajectory of 668, and the adjusted backlog target of 761 • Latest FDS performance (Feb 23) 72.8% against the trajectory of 73.98% and the planning target of 75%. March / year end performance due to be released 12.05 and a verbal update will be provided at the Board • 23/24 Planning update and work programme • Update on Oncology Outpatient Consolidation and SQD work programmes • Programme risk and mitigations
Consulted	Operational Performance presented to GM Chief Operating Officers
Author of paper and contact details	**Name: Lisa Galligan-Dawson** **Title: Director of Performance, GM Cancer** **Email: lisa.galligan-dawson@nhs.net**

1 Background and Context

This paper provides the GM Cancer Board with an update on performance against the 22/23 key planning objectives, alongside the national Cancer Waiting Times Standards (CWT) for the latest reported month (February 23).

Additionally, the paper provides an update on the current 23/24 work programme, the Consolidation of Oncology Outpatients and SQD projects and identified risks and mitigation.

2 Key discussion points

22/23 Key Planning Objectives and Performance

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%			

Backlog Reduction

At the end of March 23 the provisional backlog (volume of patients from a 2ww referral source on an active PTL over 62 days) was 820. This is 152 more than the GM trajectory of 668 and 59 above the pre-pandemic adjusted baseline of 761 (the national target). Despite not achieving the target this represents significant improvement from the end of Q2 position of 2252. It should also be noted that in real terms this is an improvement on the pre-covid position of 850. (761 is an adjusted figure based on NHSE assessment of how big they assessed our backlog should have been given the England total backlog. This does not consider deprivation).

The performance by organisation is detailed below. Four organisations achieved their individual target.

Month Ending / Provider	June 22 Trajectory	June 22 Actual	July 22 Trajectory	July 22 Actual	Aug 22 Trajectory	Aug 22 Actual	Sep 22 Trajectory	Sep 22 Actual	Revised Oct 22 Trajectory	Oct 22 Actual	Revised Nov 22 Trajectory	Nov 22 Actual	Revised Dec 22 Trajectory	Dec 22 Actual	Revised Jan 23 Trajectory	Jan 23 Actual	Revised Feb 23 Trajectory	Feb 23 Actual	Revised Mar 23 Trajectory	Mar 23 (& Year end) Actual
Bolton	14	34	13	39	13	36	15	32	35	36	32	24	29	19	26	20	23	22	20	14
MFT	688	756	589	732	490	746	490	997	827	981	691	869	555	812	385	638	247	375	100	274
NCA	500	455	430	532	333	748	222	793	925	749	925	588	749	649	573	588	397	420	222	200
Stockport	105	100	100	106	95	103	95	94	90	77	85	80	90	90	85	91	80	97	75	78
Tameside	125	84	112	92	103	150	88	152	150	194	157	142	156	239	155	211	150	159	145	128
The Christie	65	81	65	107	65	97	65	86	85	86	85	98	85	92	85	94	85	132	85	74
WWL	130	128	110	94	100	112	100	98	87	91	78	97	78	116	65	92	45	65	21	52
GM TOTAL	1627	1638	1419	1702	1199	1992	1075	2252	2199	2214	2053	1898	1742	2017	1374	1734	1027	1270	668	820

Faster Diagnosis Standard

The Faster Diagnosis performance for year end 22/23 is not yet reported. The latest position is February 23 where GM performance was 72.8% against the trajectory of 73.83% and the planning target of 75%. Although performance reported is significantly improved, the data completeness levels remain low from MFT (as reported to the March 23 GM Cancer Board). Therefore, in reality performance would be lower if data completeness was aligned to expected standards. The impact of data completeness is not known but is estimated to be at least 2% at GM level.

Performance at Trust level is detailed overleaf.

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	Feb. Trajectory	Feb. Actual
GM SYSTEM	13128	10234	14435	11969	13544	14058	12619	11451	14054	12958	12940	12572
	66.54	59.80%	68.25	59.40%	70.40	62.00%	71.74%	64.90%	71.52%	63.40%	73.98%	72.80%
Bolton	1376	1596	1388	1534	1380	1642	1422	1382	1387	1355	1313	1435
	85.47	80.10%	84.58	81.60%	76.96	80.10%	81.72%	81.30%	80.39%	77.60%	88.88%	84.70%
MFT*	4910	1714	6131	2916	4899	4153	4899	3308	6111	4051	4892	3820
	57.86	49.60%	61.67	61.80%	64.14	65.80%	64.89%	68.70%	65.34%	68.40%	65.51%	76.90%
NCA	3258	3252	3110	3656	3258	4167	2962	3531	3110	3940	2961	3772
	62.98	44.70%	66.98	42.20%	70.99	48.50%	74.98%	52.10%	74.98%	52.40%	75.01%	65.10%
Stockport	1165	1217	1105	1123	1165	1195	1045	1005	1090	1116	928	1024
	65.06	62.90%	68.05	67.40%	70.04	62.60%	72.06%	68.50%	72.02%	61.60%	75.00%	73.30%
Tameside	1064	1228	1316	1199	1487	1377	1066	1177	1071	1282	1589	1117
	89.66	64.00%	81.84	57.40%	81.84	55.30%	80.02%	57.90%	83.19%	59.40%	84.08%	69.00%
Christie	5	5	5	2	5	12	5	6	5	9	5	7
	100	40.00%	100	0%	100.00	58.30%	100.00%	33.30%	100.00%	11.10%	100.00%	42.90%
WWL	1350	1162	1380	1539	1350	1506	1220	1042	1280	1205	1260	1396
	70.37	81.00%	71.01	69.50%	72.59	74.80%	72.13%	78.70%	72.66%	72.70%	75.40%	73.30%

First Definitive Treatment Volumes

As reported in the GM Cancer Board paper of March 23 the national reported position for GM in terms of overall delivery will not be accurate until the national data refresh (only undertaken bi-annually) is complete. Data added late from NCA due to their IT outage and from MFT and their HIVE implementation is currently not included in the overall recovery position (calculated as cumulative from March 2020) which is showing as 94%. The current month (February 23) reports 87% of first treatments compared with the same period 19/20. The actual volumes were 1154 against the plan of 1325. The overall position is expected to improve when the data refresh takes place, but it is not clear by how much.

Cross Cutting High Impact Project Update

There are two system wide improvement initiatives spanning multiple pathways and organisations; Single Queue Diagnostics and Consolidation of Oncology Outpatients that are due formal updates. Progress is detailed below.

Consolidation of Oncology Outpatients

This initiative plans to consolidate outpatient oncology provision under The Christie NHS Foundation Trust, this was agreed with the intention of creating a single queue for all new

referrals to reduce waits for a first appointment following a cancer diagnosis. Additionally this initiative intends to improve utilisation, reduce variation and inequity of waiting time access and enable a GM overview of oncology clinic capacity across GM.

At present, The Christie employs the Oncologists delivering outpatient care for patients in GM. There are currently three oncology outpatient models in place.

- Christie activity delivered at The Christie.
- Christie activity delivered in local trusts and Primary care.
- Activity delivered locally via an SLA with the Christie.

For the latter, a 42/52 week SLA is set up between The Christie and the host trust to recharge for the Consultant time. Capacity for the clinics delivered via SLA is booked, co-ordinated and managed by the individual Trust (including variable patient flow). The activity and income are also recorded and owned by each individual Trust.

Current Operating Models by Site and Consolidation Requirements

Wigan/East Cheshire/Mid Cheshire – Christie @ model (Christie activity supported by an agreed SLA for resource to deliver activity). No further work necessary.

NCA (Oldham and Salford) – SLA for Breast, Urology, Lung, H&N oncology outpatient clinic provision. Outpatient activity to be transferred.

Bolton – SLA for Breast, Lung, Urology, GI oncology outpatient clinic provision. Outpatient and SACT activity to be transferred.

Stockport – SLA for Breast, Urology, Lung oncology outpatient clinic provision. Outpatient activity to be transferred.

MFT (MRI, Wythenshawe and North Manchester) – SLA for LGI, Breast and Lung Outpatient Clinic provision. Request to transfer both outpatient and SACT activity.

Tameside – SLA for Lung and Breast Outpatient clinic provision. Outpatient activity to be transferred.

Future State

To transfer all Solid tumour Oncology Outpatient activity ownership to The christie with the intention to create a single queue for first appointment and offer a choice to patients with the option of the earliest available appointment within any of the Trusts with an outpatient service for their disease group.

This is a highly complex improvement initiative involving activity transfer and associated finances, SLA design, operational change management, multiple clinical systems, new booking systems and processes.

It is expected that the first transfer creates a road map, and transferable work lists and documentation for the following sites. Therefore, transfer of the subsequent sites is expected to be much quicker than the process with the first site (Bolton). A further complexity adding to the transfer time is that Bolton have also requested to transfer their SACT activity. This is outside the scope of this initiative, but has been agreed directly between the two organisations. The following table gives a high level assessment of the current progress and timeline. Bolton and Christie have agreed a transfer date for 01.07.23

Trust	Initial Meeting with service leads	MDS received	Follow up meeting	Further requested info received	Consultants updated	Agreed start date	comments
Bolton	Yes	Yes	Yes	Yes	Yes	Yes	1st July 2023
Tameside	Yes	Yes	Yes	No	Yes	No	Plan for July transfer
NCA (Oldham)	Yes	Yes	Yes	Yes	Yes	No	Plan for August transfer
NCA (Salford)	Yes	Yes	No	No	No	No	Awaiting further information
MFT (MRI)	Yes	Yes	Yes	Part	Yes	No	Plan for July transfer
MFT (North Manchester)	Yes	Yes	No	Part	Part	No	Awaiting pharmacy information
MFT Wythenshawe							Not yet started
Stockport	Yes	No	No	No	No	No	Awaiting further information

Next steps:

1. Transfer Bolton activity, and complete lessons learnt assessment and roadmap documentation
2. Agree definitive transfer dates with Tameside, Oldham and MRI

3. Re-create engagement with Wythenshawe and Stockport as priority as all sites need to consolidate before the full benefits of the initiative will be realised

Single Queue Diagnostics

The concept creates a single platform for specialist / niche diagnostics bringing together, for the first time, all available capacity from all GM organisations into one view. Requesting clinicians are able to directly book and co-ordinate appointments at any of the GM sites with the patient in clinic. Multiple sequenced diagnostics will be available to book together to reduce the overall wait between tests and enable these to be co-ordinated to MDT discussion dates. This is in contrast to the current process which has rigid referral structures through fixed site provision and passes the scheduling process to other organisations in silos. The pilot was based on EBUS (Lung) and EUS (OG) at a small number of GM sites. The pilot delivered notable improvement in waiting times, reduced variation and had high levels of patient satisfaction.

Following the success of the pilot and the potential this initiative offers in system working and pathway improvement, the GM Cancer Alliance was able to secure substantial funds from the National Cancer Programme to test at scale. The current expansion (up to March 24) is to include the roll out of EBUS and EUS to all GM sites, to expand into interventional radiology (commencing roll out with CT guided lung biopsy), to roll out diagnostic / staging PET-CT scans, to roll out in other specialist / niche diagnostics in the lung pathway (Thoracoscopy / Plural), to roll out in a niche service with limited resilience (CTC identified).

This plan aims demonstrate single queues are achievable in complex & challenging procedures, allowing testing across a wider range of tumour sites (i.e. gynaecology, H&N, Urology, LGI in PET-CT) to test the synchronisation of multiple diagnostics (Lung / OG), to test co-ordination of a range of complex diagnostics from a referring organisation, to test patient choice experience at scale, to assess the impact on service resilience, to assess the impact to waiting times, variation and health inequalities, and finally to determine the scalability and system potential for other areas of cancer diagnostics and beyond.

Benefits are expected to include improved collaborative networks and system working, breakdown organisational barriers, maximise diagnostic capacity and utilisation of assets, reduce waiting times and variation and improve experience of care.

The current position is as follows:

- Programme governance structure operationalised
- Weekly sub-group meetings
- Weekly steering group meeting
- System specification & design completed for PET-CT, EBUS, EUS, Lung Biopsy, Thoracoscopy (EUS and Lung Biopsy awaiting final sign off)
- System build and user testing commenced in PET-CT, EBUS and Thoracoscopy
- Standard operating procedures and patient information created for EBUS

Final testing and operationalisation plans are now being created for EBUS which is expected to go live in all remaining sites end of May / Early June.

Significant operational and clinical engagement is underway to move the other areas forward. Thoracoscopy is a highly invasive procedure and this will create a clear road map for other areas. CT guided biopsy has been the most challenging given the complexity, high risk, and recovery / after care requirements but is also the greatest success with a definitive pathway and plan for implementation.

Given the crucial stage of the project a further update will be provided at the next GM Cancer Board.

Cancer Waiting Times Standards (CWT) February 23

The latest reportable position for Greater Manchester (February 23) shows an increase in 2ww performance of 9%, FDS performance of 9%, 31 DTT performance by 6%, subsequent surgery by 6% and overall 62 day RTT of 8% compared to January 23.

The performance against the constitutional standards by provider and tumour site is detailed below. The trend analysis against each metric can be found in **Appendix 1.**

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: February 2023 to February 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	85.4%	72.8%	93.2%	100.0%	99.3%	92.1%	59.4%	70.8%	77.0%
Bolton NHS Foundation Trust	75.4%	84.7%	100.0%	100.0%		80.0%	74.4%	71.0%	85.7%
Manchester University NHS Foundation Trust	79.5%	76.9%	85.1%	100.0%	0.0%	73.3%	47.4%	41.9%	76.1%
Northern Care Alliance NHS Foundation Trust	86.5%	65.1%	90.6%	100.0%		100.0%	55.8%	79.7%	33.3%
Stockport NHS Foundation Trust	98.2%	73.3%	92.2%				62.0%	87.0%	0.0%
Tameside And Glossop Integrated Care NHS Foundation Trust	90.6%	69.0%	100.0%	100.0%			42.2%	66.7%	0.0%
The Christie NHS Foundation Trust	100.0%	42.9%	98.3%	100.0%	99.5%	100.0%	79.4%	78.8%	100.0%
Wrightington, Wigan And Leigh NHS Foundation Trust	96.8%	73.3%	98.9%	100.0%		100.0%	78.9%	81.2%	84.6%

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: February 2023 to February 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	**85.4%**	**72.8%**	**93.2%**	**100.0%**	**99.3%**	**92.1%**	**59.4%**	**70.8%**	**77.0%**
Acute Leukaemia	75.0%	100.0%					75.0%	66.7%	
Brain/CNS	82.6%	86.1%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	
Breast	80.9%	93.5%	87.7%	100.0%	100.0%	79.2%	69.2%	66.7%	85.7%
Breast Symptomatic	70.7%	84.3%							
Children's	88.2%	87.5%			100.0%				
Gynaecological	80.6%	55.9%	98.4%	100.0%	97.2%	85.7%	53.2%	74.2%	66.7%
Haematological			98.4%	100.0%	100.0%	100.0%			
Haematological (Excluding A..	95.1%	77.9%					52.0%	73.9%	
Head and Neck	82.1%	70.2%	88.6%	100.0%	100.0%	100.0%	45.9%	57.1%	
Lower Gastrointestinal	89.7%	57.6%	95.8%	100.0%	100.0%	100.0%	43.0%	79.4%	41.7%
Lung	87.2%	84.7%	98.8%	100.0%	100.0%	100.0%	56.2%	63.3%	
Other	85.7%	81.3%	88.9%	100.0%	100.0%	100.0%	50.0%	90.0%	
Sarcoma	67.3%	76.0%	93.8%	100.0%	100.0%	100.0%	37.5%	33.3%	
Skin	87.4%	77.2%	83.2%	100.0%	100.0%	97.9%	65.8%	73.0%	
Testicular	100.0%	88.6%					100.0%	50.0%	
Unknown		30.0%							
Upper Gastrointestinal	89.7%	73.6%	95.9%	100.0%	94.1%	100.0%	68.0%	68.9%	
Urological			94.9%	100.0%	98.7%	100.0%			
Urological (Excluding Testicu..	92.4%	67.1%					57.4%	80.0%	

23/24 Planning update and work programme

The ICS / system level planning guidance contains two cancer performance related metrics.

1. Continue to reduce the number of patients waiting over 62 days
2. Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.

The backlog reduction target set by NHSE for GM is 1051 (which would represent a deterioration on the 22/23 year end position of 820. Internally, it has been agreed to work towards the original target of 761 to deliver continuous improvement.

The following trajectory has been submitted:

	TARGET	April 2023	May 2023	June 2023	July 2023	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	373	299	320	315	305	292	312	325	345	355	367	315	267
THE CHRISTIE NHS FOUNDATION TRUST	75	80	80	80	80	80	80	80	80	80	80	80	80
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	292	222	244	266	288	310	310	266	222	212	199	186	175
BOLTON NHS FOUNDATION TRUST	18	24	26	28	30	30	32	30	26	26	23	18	18
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	101	140	137	128	125	124	131	125	115	109	117	108	101
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	107	95	83	74	66	58	51	43	39	35	31	26	21
STOCKPORT NHS FOUNDATION TRUST	85	103	128	120	128	125	120	79	72	82	96	89	82
TOTAL	1051	963	1,018	1,011	1,022	1,019	1,036	948	899	899	913	822	744

Performance in April 23 is as follows:

	PLANNING TARGET	April 23 Trajectory	April 23 Actual
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	373	299	352
THE CHRISTIE NHS FOUNDATION TRUST	75	80	78
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	292	222	355
BOLTON NHS FOUNDATION TRUST	18	24	20
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	101	140	127
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	107	95	89
STOCKPORT NHS FOUNDATION TRUST	85	103	151
TOTAL	1051	963	1,172

The FDS delivery requires incremental growth at the end of June 23, September 23, December 23 as well as the March 24 target. There will be monitoring at individual Trust level as well as system level performance. The requirements are as follows:

	Jun-23	Sep-23	Dec-23	Mar-24
BOLTON NHS FOUNDATION TRUST	67.50%	70.00%	72.50%	**75.00%**
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	67.50%	70.00%	72.50%	**75.00%**
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	67.50%	70.00%	72.50%	**75.00%**
STOCKPORT NHS FOUNDATION TRUST	67.50%	70.00%	72.50%	**75.00%**
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	67.50%	70.00%	72.50%	**75.00%**
THE CHRISTIE NHS FOUNDATION TRUST	67.50%	70.00%	72.50%	**75.00%**
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	67.50%	70.00%	72.50%	**75.00%**
GM SYSTEM TOTAL	**67.50%**	**70.00%**	**72.50%**	**75.00%**

The trajectory submitted is as follows

		April 2023	May 2023	June 2023	July 2023	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	Numerator	2298	2435	**2798**	2766	2763	**2631**	2689	2981	**2712**	2813	3126	**3008**
	Denominator	3677	3746	**4145**	4050	3999	**3758**	3798	4163	**3741**	3838	4218	**4011**
	%	62.5	65	**67.5**	68.3	69.09	**70.01**	70.8	71.61	**72.49**	73.29	74.11	**74.99**
THE CHRISTIE NHS FOUNDATION TRUST	Numerator	5	5	**5**	5	5	**5**	5	5	**5**	5	5	**5**
	Denominator	6	6	**6**	6	6	**6**	6	6	**6**	6	6	**6**
	%	83.33	83.33	**83.33**	83.33	83.33	**83.33**	83.33	83.33	**83.33**	83.33	83.33	**83.33**
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	Numerator	2174	2242	**2361**	2361	2361	**2446**	2446	2446	**2531**	2531	2582	**2616**
	Denominator	3397	3397	**3397**	3397	3397	**3397**	3397	3397	**3397**	3397	3397	**3397**
	%	64	66	**69.5**	69.5	69.5	**72**	72	72	**74.51**	74.51	76.01	**77.01**
BOLTON NHS FOUNDATION TRUST	Numerator	1095	1364	**1281**	1293	1423	**1341**	1289	1379	**1161**	1161	1153	**1171**
	Denominator	1369	1705	**1601**	1616	1779	**1676**	1611	1724	**1451**	1451	1441	**1463**
	%	79.99	80	**80.01**	80.01	79.99	**80.01**	80.01	79.99	**80.01**	80.01	80.01	**80.04**
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	Numerator	738	813	**731**	803	906	**942**	889	1007	**960**	928	889	**920**
	Denominator	1191	1251	**1083**	1181	1313	**1346**	1253	1408	**1325**	1262	1201	**1226**
	%	61.96	64.99	**67.5**	67.99	69	**69.99**	70.95	71.52	**72.45**	73.53	74.02	**75.04**
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	Numerator	860	970	**1001**	1012	1010	**1050**	1070	1013	**906**	1010	1025	**990**
	Denominator	1175	1306	**1436**	1371	1436	**1371**	1436	1436	**1240**	1436	1371	**1306**
	%	73.19	74.27	**69.71**	73.81	70.33	**76.59**	74.51	70.54	**73.06**	70.33	74.76	**75.8**
STOCKPORT NHS FOUNDATION TRUST	Numerator	731	809	**929**	897	950	**935**	961	934	**835**	899	929	**886**
	Denominator	1044	1160	**1276**	1218	1276	**1218**	1276	1276	**1102**	1276	1218	**1160**
	%	70.02	69.74	**72.81**	73.65	74.45	**76.77**	75.31	73.2	**75.77**	70.45	76.27	**76.38**

In addition, the Cancer Alliance planning requirements require the following deliverables:

1. Deliver BPTP milestones in suspected prostate, lower GI, skin and breast cancer pathways
2. Deliver 100% population coverage for Non-Specific Symptoms (NSS) pathways

<u>Treatment Variation</u>

The Cancer Alliance planning requirements are as follows:

1. Alliances to continue to oversee the implementation of three selected treatment recommendations from the national lung Getting It Right First Time (GIRFT) report
2. Alliances to oversee the implementation of one priority recommendation from each of three existing clinical audits for cancers other than lung cancer: Breast, Prostate & Bowel

Quarterly reporting on all these metrics will be included in the forthcoming Cancer Board papers.

Work Programme 23/24

A comprehensive work programme has been designed to address the planning requirements, and make tangible and sustainable improvements to patients, pathways and thus performance. These span all pathways but with key emphasis on pathways identified by NHSE as high priority (LGI, Prostate, Skin, Breast) alongside local priorities (Lung, Gynaecology, Bladder).

Following a comprehensive assessment of pathway performance, the basis of the new initiatives identified for delivery in 23/24 are aligned to the key challenges. These complement the initiatives already delivered or in train from work that commenced during 22/23 and those rolled out but in pilot form (with associated planned evaluation). A number of these represent work across the entire cancer system and delivery spans the breadth of the Cancer Alliance team.

The proposed initiatives below are planned in conjunction with all Clinical Pathway Board leads. The work programme includes an element of flexibility where new actions are identified, or to respond to new or exacerbated pathway challenges.

Domain	Speciality	Item
FDS - BPTP	Lower GI	CTC pathway redesign
OP		CTC single queue
FDS - BPTP	Skin	Seborrhoeic Keratosis pathway management
FDS - BPTP		Actinic Keratosis pathway management
FDS - BPTP		Referral management pilot
FDS - BPTP	Urology	MR & LATP Capacity increase
OP		TULA expansion
OP		TURBT pathway re-design and hub
FDS - BPTP	Gynaecology	One stop provision /expansion / TV USS OP Hy
FDS - BPTP		IP Hysteroscopy pathway

FDS - BPTP	H&N	USS FNA One Stop training and roll out
FDS - BPTP	Breast	Under 40 and male pathway development
OP	OG	Roll out of one stop service
OP	Lung	Model of care delivery
OP	Cross Cutting	Pilot on shared radiology reporting
FDS - BPTP		First Offer work programme
FDS - BPTP		Diagnostic bundle roll out / expansion

To support traction in delivery and programme rigor a revised governance structure is being implemented with the first Programme Board scheduled for 24.05.23.

Programme Risk and Mitigation

Risk	Mitigating actions
ICB financial situation limiting additional activity delivered in Q4	Support for tier 1 Focussed pathway improvement work to deliver sustainable improvement Unable to mitigate in full.
Issues pertaining to G&A bed occupancy, NRTR, Theatre availability, diagnostic capacity (test and reporting), workforce and industrial action	Work with GM EMDs, COOs, Diagnostic Networks Trajectory for surgical treatment and monitoring Unable to mitigate in full.
Elective 65/ 78 weeks / DM01	Retain focus on Cancer in all tier 1 calls, and other forums Retain close working relationships with ER team Unable to mitigate in full.
CDC delivery - Significantly challenged programme of work. Significant delays and concern will not contribute to the 25% diagnostic growth needed	Increased cancer alliance bandwidth to support National letter of support for cancer and close working to deliver required outputs Unable to mitigate in full.

Diagnostic capacity impacting the ability to deliver milestone waits	Attendance at appropriate forums. New diagnostic board being established. C&D requested. Unable to mitigate in full.
23/24 planning guidance – lack of ambition	Stretch targets agreed and will be monitored
Fragile services – Dermatology and Breast, Gynaecology	GM work programmes
Mutual aid lists not fully utilised.	Actions currently with MFT and NCA

3 Next steps

The programme of work will continue and updates provided to the appropriate forums and GM Cancer Board. Escalation will be enacted where appropriate.

4 Recommendation, requests / support required of the Board

To note the contents of this report and to provide full support for the delivery of the actions necessary to deliver the planning requirements and ambitions for cancer patients in GM. This includes support to ensure sufficient dedicated diagnostic and surgical capacity.

Appendix 1

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 - 202..	2022 - 2023 FY										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Bolton NHS Foundation Trust	78.5% n=1,523.0	86.3% n=1,158.0	89.0% n=1,437.0	88.2% n=1,376.0	95.0% n=1,359.0	96.0% n=1,570.0	92.6% n=1,423.0	84.8% n=1,335.0	91.4% n=1,391.0	79.3% n=1,169.0	82.4% n=1,167.0	80.7% n=1,280.0
Manchester University NHS Foundation Trust	61.7% n=4,594.0	59.1% n=3,617.0	67.3% n=4,417.0	57.1% n=4,187.0	55.1% n=4,704.0	53.9% n=4,995.0	43.8% n=3,937.0	40.5% n=4,560.0	54.2% n=5,487.0	63.5% n=4,081.0	67.8% n=4,468.0	79.5% n=4,451.0
Northern Care Alliance NHS Foundation Trust	77.1% n=3,757.0	69.4% n=3,305.0	71.2% n=3,683.0	67.8% n=3,169.0	73.7% n=3,561.0	64.2% n=4,005.0	56.0% n=3,798.0	63.0% n=4,188.0	64.4% n=4,806.0	63.1% n=3,780.0	72.3% n=4,153.0	86.5% n=3,747.0
Pennine Care NHS Foundation Trust							100.0% n=2.0					
Stockport NHS Foundation Trust	98.2% n=1,229.0	94.3% n=1,060.0	96.9% n=1,142.0	93.2% n=1,094.0	96.3% n=1,121.0	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	98.2% n=1,071.0
Tameside And Glossop Integrated Care ..	94.6% n=1,395.0	93.4% n=1,202.0	94.3% n=1,340.0	91.1% n=1,210.0	83.7% n=1,274.0	72.4% n=1,430.0	71.1% n=1,283.0	73.8% n=1,250.0	72.4% n=1,219.0	66.6% n=1,241.0	75.6% n=1,283.0	90.0% n=1,060.0
The Christie NHS Foundation Trust	100.0% n=1.0	100.0% n=4.0	85.7% n=7.0	87.5% n=8.0	90.0% n=10.0	71.4% n=7.0	100.0% n=4.0		100.0% n=7.0	77.8% n=9.0	83.3% n=6.0	100.0% n=8.0
Wrightington, Wigan And Leigh NHS Foundation ..	93.2% n=1,666.0	93.1% n=1,310.0	95.7% n=1,523.0	92.8% n=1,539.0	94.1% n=1,394.0	90.9% n=1,635.0	82.1% n=1,554.0	93.8% n=1,510.0	97.0% n=1,616.0	98.1% n=1,289.0	96.7% n=1,338.0	96.7% n=1,467.0
ICB Total	**77.7% n=14,165.0**	**75.3% n=11,656.0**	**79.0% n=13,549.0**	**74.0% n=12,583.0**	**74.3% n=13,423.0**	**70.6% n=14,871.0**	**64.8% n=13,239.0**	**64.9% n=13,940.0**	**69.9% n=15,723.0**	**71.5% n=12,574.0**	**76.4% n=13,476.0**	**86.0% n=13,084.0**

Greater Manchester Cancer

NHS Greater Manchester Integrated Care

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 - 202..	2022 - 2023 FY									
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Bolton NHS Foundation Trust	82.3% n=1,767.0	82.0% n=1,309.0	80.2% n=1,623.0	81.4% n=1,524.0	80.8% n=1,543.0	83.8% n=1,697.0	80.1% n=1,600.0	81.6% n=1,534.0	80.1% n=1,642.0	81.3% n=1,382.0	77.6% n=1,355.0	84.7% n=1,435.0
Manchester University NHS Foundation Trust	55.2% n=4,625.0	45.9% n=3,590.0	55.0% n=3,843.0	41.3% n=3,669.0	55.1% n=4,459.0	62.0% n=4,609.0	55.4% n=2,314.0	61.8% n=2,916.0	65.8% n=4,153.0	68.7% n=3,308.0	68.4% n=4,051.0	76.9% n=3,820.0
Northern Care Alliance NHS Foundation Trust	65.9% n=3,506.0	58.2% n=3,322.0	63.9% n=3,077.0	47.1% n=3,288.0	47.9% n=2,925.0	45.2% n=3,365.0	44.6% n=3,250.0	42.2% n=3,656.0	48.5% n=4,167.0	52.1% n=3,531.0	52.4% n=3,940.0	65.1% n=3,773.0
Stockport NHS Foundation Trust	70.0% n=1,150.0	58.5% n=1,073.0	62.1% n=1,087.0	60.4% n=1,033.0	63.4% n=1,149.0	64.1% n=1,188.0	62.9% n=1,218.0	67.4% n=1,123.0	62.6% n=1,195.0	68.5% n=1,005.0	61.6% n=1,116.0	73.3% n=1,024.0
Tameside And Glossop Integrated Care NHS Foundation ..	80.1% n=1,196.0	77.5% n=1,163.0	77.9% n=1,215.0	70.6% n=1,173.0	70.3% n=1,313.0	75.4% n=1,272.0	63.8% n=1,295.0	57.4% n=1,199.0	55.3% n=1,377.0	57.9% n=1,177.0	59.4% n=1,282.0	69.0% n=1,117.0
The Christie NHS Foundation Trust	100.0% n=1.0	100.0% n=3.0	75.0% n=4.0	100.0% n=1.0	64.3% n=14.0	20.0% n=5.0	33.3% n=6.0	0.0% n=2.0	58.3% n=12.0	33.3% n=6.0	11.1% n=9.0	42.9% n=7.0
Wrightington, Wigan And Leigh NHS Foundation Trust	73.6% n=1,548.0	65.9% n=1,353.0	64.4% n=1,581.0	71.2% n=1,397.0	68.4% n=1,343.0	71.4% n=1,408.0	80.9% n=1,163.0	69.5% n=1,539.0	74.8% n=1,506.0	78.7% n=1,042.0	72.7% n=1,205.0	73.3% n=1,396.0
ICB Total	**66.9% n=13,793.0**	**59.9% n=11,813.0**	**64.5% n=12,430.0**	**55.9% n=12,085.0**	**60.3% n=12,746.0**	**63.0% n=13,544.0**	**60.4% n=10,846.0**	**59.4% n=11,969.0**	**62.0% n=14,052.0**	**64.9% n=11,451.0**	**63.4% n=12,958.0**	**72.8% n=12,572.0**

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 - 202..	2022 - 2023 FY									
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Bolton NHS Foundation Trust	81.7% n=84.5	85.2% n=61.0	85.8% n=95.0	81.5% n=73.0	83.6% n=79.5	80.2% n=88.5	78.8% n=68.5	83.2% n=89.5	80.8% n=83.5	81.6% n=62.5	84.2% n=69.5	74.4% n=64.5
Manchester University NHS Foundation Trust	55.4% n=219.5	50.2% n=201.0	31.6% n=169.5	40.5% n=202.5	44.4% n=205.0	44.5% n=199.0	32.6% n=136.5	29.6% n=79.5	37.6% n=131.5	44.2% n=121.0	33.9% n=166.5	47.4% n=180.5
Northern Care Alliance NHS Foundation Trust	65.3% n=147.0	57.1% n=161.0	50.5% n=147.5	44.7% n=159.0	47.0% n=165.0	48.1% n=154.0	41.9% n=173.0	40.1% n=151.0	44.7% n=206.0	51.6% n=168.5	40.9% n=181.0	55.8% n=172.0
Stockport NHS Foundation Trust	79.3% n=55.5	85.1% n=43.5	52.8% n=61.5	60.5% n=62.0	61.0% n=77.0	67.8% n=59.0	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	62.0% n=46.0
Tameside And Glossop Integrated Care NHS Foundation ..	77.0% n=50.0	88.8% n=49.0	73.9% n=55.5	59.2% n=38.0	59.5% n=42.0	70.9% n=43.0	63.3% n=60.0	59.8% n=46.0	59.8% n=43.5	58.7% n=37.5	37.1% n=44.5	42.2% n=45.0
The Christie NHS Foundation Trust	80.7% n=70.0	80.1% n=78.0	71.8% n=71.0	77.4% n=68.5	86.3% n=58.5	71.7% n=60.0	73.3% n=67.5	78.3% n=53.0	81.7% n=87.5	77.9% n=65.5	66.3% n=84.5	79.4% n=63.0
Wrightington, Wigan And Leigh NHS Foundation Trust	71.9% n=64.0	67.9% n=79.5	77.8% n=81.0	76.3% n=78.0	71.0% n=81.0	70.2% n=80.5	73.0% n=50.0	75.0% n=80.0	76.7% n=75.0	76.0% n=60.5	72.8% n=57.0	78.9% n=61.5
ICB Total	**68.3% n=690.5**	**65.7% n=673.0**	**58.3% n=681.0**	**56.5% n=681.0**	**58.6% n=708.0**	**59.0% n=684.0**	**54.7% n=615.0**	**58.6% n=567.5**	**59.8% n=701.5**	**61.9% n=579.0**	**51.0% n=669.0**	**59.4% n=632.5**

Greater Manchester Cancer

NHS Greater Manchester Integrated Care

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..	2022 - 2023 FY										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Grand Total	**77.7%**	**75.3%**	**79.0%**	**74.0%**	**74.3%**	**70.6%**	**64.8%**	**64.9%**	**69.9%**	**71.5%**	**76.4%**	**86.0%**
Acute Leukaemia	100.0%	100.0%		50.0%	100.0%		100.0%	100.0%	100.0%	100.0%	0.0%	75.0%
Brain/CNS	95.2%	98.4%	93.2%	93.1%	93.0%	69.1%	51.9%	49.7%	72.3%	92.0%	71.1%	82.6%
Breast	31.6%	33.8%	52.4%	36.7%	34.0%	40.8%	40.3%	42.4%	58.6%	67.1%	71.3%	80.9%
Children's	84.8%	71.9%	83.6%	68.2%	75.4%	68.9%	78.9%	68.4%	58.4%	73.7%	69.1%	88.2%
Gynaecological	95.1%	89.1%	93.2%	89.5%	88.3%	82.3%	66.8%	72.1%	74.9%	74.9%	73.2%	80.6%
Haematological (Excluding A..	93.6%	95.7%	94.7%	96.1%	93.3%	90.3%	91.4%	84.7%	94.2%	85.7%	91.4%	95.1%
Head and Neck	88.1%	74.8%	79.0%	77.7%	72.9%	76.9%	74.3%	77.5%	73.2%	80.9%	82.6%	82.1%
Lower Gastrointestinal	93.4%	94.8%	96.0%	89.1%	93.3%	83.4%	79.0%	86.2%	87.2%	89.8%	89.0%	89.7%
Lung	98.8%	88.3%	94.0%	93.7%	96.3%	98.0%	94.1%	94.2%	95.4%	91.0%	89.9%	87.2%
Other	93.5%	86.8%	94.3%	93.0%	88.7%	88.8%	75.0%	93.5%	78.3%	90.9%	89.5%	85.7%
Sarcoma	56.4%	57.7%	83.6%	78.9%	95.1%	64.9%	79.8%	57.1%	40.9%	55.7%	55.1%	67.3%
Skin	65.1%	58.6%	56.9%	49.0%	53.8%	47.0%	28.9%	28.9%	38.4%	32.4%	56.9%	87.4%
Testicular	96.1%	97.6%	97.8%	96.6%	97.4%	92.7%	94.7%	79.2%	97.9%	100.0%	94.5%	100.0%
Upper Gastrointestinal	96.3%	91.0%	91.1%	91.9%	93.8%	91.9%	85.4%	86.0%	85.5%	77.6%	78.7%	89.7%
Urological (Excluding Testicu..	93.0%	91.5%	92.3%	92.5%	94.8%	90.3%	89.2%	79.3%	84.0%	88.1%	88.2%	92.4%

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..	2022 - 2023 FY										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Grand Total	**66.9%**	**59.9%**	**64.5%**	**55.9%**	**60.3%**	**63.0%**	**60.4%**	**59.4%**	**62.0%**	**64.9%**	**63.4%**	**72.8%**
Acute Leukaemia	100.0%			100.0%	50.0%	0.0%		66.7%	100.0%	0.0%	0.0%	100.0%
Brain/CNS	77.6%	80.1%	84.0%	88.2%	87.7%	83.8%	71.1%	78.3%	78.1%	77.7%	75.7%	86.1%
Breast	64.4%	52.4%	67.7%	46.3%	68.8%	85.4%	90.5%	84.4%	88.4%	91.3%	90.0%	93.5%
Breast Symptomatic	62.5%	54.1%	54.6%	44.6%	58.2%	80.5%	86.1%	77.4%	85.3%	89.1%	87.6%	84.3%
Children's	92.2%	72.4%	93.8%	88.6%	89.2%	86.2%	69.2%	73.1%	63.0%	75.7%	90.3%	87.5%
Gynaecological	70.4%	65.2%	67.6%	66.7%	58.1%	61.4%	50.3%	51.1%	51.6%	52.0%	44.9%	55.9%
Haematological (Excluding A..	72.9%	68.8%	71.1%	69.2%	77.9%	72.4%	76.1%	69.3%	75.7%	68.1%	68.6%	77.9%
Head and Neck	71.9%	64.8%	65.4%	63.0%	56.5%	56.8%	62.7%	62.3%	61.8%	66.5%	64.1%	70.2%
Lower Gastrointestinal	53.1%	48.5%	51.6%	46.1%	52.4%	49.4%	49.5%	50.8%	53.1%	57.7%	46.7%	57.6%
Lung	84.8%	80.7%	77.3%	70.5%	65.4%	64.8%	72.4%	80.8%	82.8%	85.0%	81.4%	84.7%
Other	52.5%	71.4%	64.3%	75.4%	58.8%	84.6%	62.5%	56.1%	66.7%	75.0%	71.4%	81.3%
Sarcoma	62.5%	63.0%	68.4%	58.3%	75.9%	65.2%	68.4%	58.3%	34.1%	45.9%	52.9%	76.0%
Skin	88.0%	75.9%	78.3%	71.2%	62.8%	58.9%	46.2%	39.5%	40.8%	44.2%	61.0%	77.2%
Testicular	90.7%	76.9%	80.6%	72.0%	78.6%	80.0%	81.5%	78.9%	79.6%	67.7%	78.0%	88.6%
Unknown	41.9%	46.7%	52.7%	51.3%	44.3%	45.0%	41.9%	45.5%	39.1%	0.0%	26.7%	30.0%
Upper Gastrointestinal	62.6%	54.3%	57.6%	48.7%	61.6%	55.9%	58.6%	56.0%	61.5%	65.9%	58.9%	73.6%
Urological (Excluding Testicu..	66.6%	64.1%	64.3%	58.5%	64.4%	63.9%	59.6%	65.4%	59.9%	58.3%	56.3%	67.1%

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..	2022 - 2023 FY										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Grand Total	**68.3%**	**65.7%**	**58.3%**	**56.5%**	**58.6%**	**59.0%**	**54.7%**	**58.6%**	**59.8%**	**61.9%**	**51.0%**	**59.4%**
Acute Leukaemia		100.0%		66.7%	100.0%	100.0%	100.0%		100.0%	100.0%		75.0%
Brain/CNS	50.0%	50.0%	0.0%		50.0%		100.0%	33.3%		100.0%		50.0%
Breast	71.2%	69.7%	55.7%	59.3%	62.5%	57.8%	63.5%	63.9%	63.7%	74.8%	64.4%	69.2%
Children's					100.0%						100.0%	
Gynaecological	52.0%	49.2%	55.4%	33.3%	42.2%	45.9%	41.8%	63.0%	49.3%	42.4%	28.6%	53.2%
Haematological (Excluding A..	71.0%	62.1%	41.7%	58.5%	69.2%	61.8%	53.8%	74.2%	70.6%	63.3%	73.1%	52.0%
Head and Neck	36.6%	40.4%	30.0%	39.5%	28.9%	40.5%	47.5%	41.1%	50.0%	56.1%	25.0%	45.9%
Lower Gastrointestinal	52.6%	55.9%	48.0%	39.7%	50.8%	44.9%	48.4%	38.2%	50.6%	50.4%	41.0%	43.0%
Lung	75.9%	58.3%	48.8%	53.0%	47.2%	52.6%	55.0%	43.4%	60.3%	56.3%	53.7%	56.2%
Other	25.0%	70.0%	50.0%	83.3%	71.4%	40.0%	100.0%	50.0%	28.6%	100.0%	60.0%	50.0%
Sarcoma	45.5%	55.6%	15.4%	0.0%	60.0%	42.9%	30.0%	0.0%	46.2%	0.0%	21.1%	37.5%
Skin	83.9%	80.3%	72.8%	68.6%	75.8%	77.1%	54.9%	64.4%	48.3%	49.4%	43.7%	65.8%
Testicular	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Upper Gastrointestinal	62.8%	57.0%	59.1%	55.2%	58.4%	56.2%	53.7%	52.1%	46.6%	60.6%	53.9%	68.0%
Urological (Excluding Testicu..	77.0%	74.8%	66.3%	64.1%	59.0%	63.5%	56.3%	70.8%	73.4%	73.1%	58.6%	57.4%

Title of paper:	**Locality Visits 2022-23 Update**
Purpose of the paper:	To update the GM Cancer Board on locality visits undertaken and proposed actions / key topics
Summary outline of main points / highlights / issues	This paper provides the GM Cancer Board with an update on the programme of locality visits led by the Cancer Alliance SMT in 2022-23
Consulted	GM Cancer Alliance SMT
Authors of paper and contact details	**Name:** Alison Jones **Title:** Director of Commissioning and Early Diagnosis, GM Cancer Alliance **Email:** alison.jones8@nhs.net **Name:** Lauren Kelly **Title:** Project Support Officer **Email:** lauren.kelly47@nhs.net

1 Background & Context

GM Cancer Alliance led a series of locality visits in 2019-20 and produced a subsequent report, presented to the Cancer Board, which informed the programme of work in the following months. This process was reintroduced in autumn 2022 with a series of visits starting in Wigan (September) and ending in Stockport (March 2023). The Manchester and Trafford localities requested a joint visit.

The purpose of the visits was to establish a 'peer to peer conversation', sharing best practice, progress, challenges / risks and determining ways in which the whole system can continue to work together. The intention has been to provide an opportunity to further strengthen relationships between GM Cancer and the localities and further develop ways of joint working and mutual support.

The approach of a peer-to-peer conversation enabled understanding of the reasons for the position in each locality and plans to address any areas of concern. This allowed the sharing of best practice from other localities and identified how the GM team can provide specific support and advice.

A standard/core agenda and set of slides was produced for all visits which was added to as required if there are locality-specific issues to address.

Some localities took the opportunity to present to the Alliance team a summary of their successes and challenges. Localities were asked to put together a list of attendees to include:

- Director of Commissioning/Equivalent
- Cancer Commissioning Manager
- Primary Care – clinical (PCN Cancer Leads as well as Macmillan GP)
- Primary Care – operational management if appropriate – for locality to determine
- Public Health
- BI
- Trust Cancer Manager
- Trust Cancer Clinical Lead and lead nurse / key secondary care clinicians
- Local VCSE / Community colleagues

Representatives from the Cancer Alliance Senior Management Team attended the meetings. SMT attendance helped to develop a better understanding of the perspective of the locality and bring messages back to Pathway Boards and project teams.

2 Key Discussion Points

Outputs from the 9 visits
All 9 meetings involved a wide-ranging discussion on topics highlighted by the Alliance and the locality teams as priorities for the specific locality. Whilst many discussions highlighted the challenges faced in delivering the cancer waiting time standards, the meetings were very focused on solutions and on sharing ways in which staff across the localities are working together to identify and address the issues. A set of notes/actions and a summary letter was produced as an output from each of the 9 meetings. **Discussions points (examples of):** Support for the ongoing relationship between the Cancer Alliance, localities and **Primary Care Networks**. Agreement that the PCN Cancer Lead roles should continue, with increased input and engagement from colleagues in localities. Bury, Manchester, Trafford and Rochdale localities gave specific presentations on the challenges in their localities from a **population health perspective** and the impact this has on cancer diagnoses. The discussions highlighted ways in which localities are identifying and addressing **inequalities**. Significant support across the localities for the **Cancer Care Co-ordinator** roles and for the wider programme of work led by the Cancer Alliance Workforce & Education Team. Whilst the localities presented developments made with the production and use of data to inform their work programmes they were also very supportive of the **Cancer Alliance BI Team** support and the information available on Tableau. Where there were specific issues and requests for additional data to be provided at a GM level (e.g. more timely staging data) these were fed back to the GM team. The presence of the Screening & Immunisation Team at the visits enabled discussions about the uptake of **cancer screening programmes** and the identification of actions to address low uptake and / or inequalities in access. Discussions on the **Faster Diagnosis Standard** enabled localities to understand how they as commissioners and providers are able to better influence patient 'compliance' with pathways and therefore have a positive impact on the delivery of the FDS A significant amount of intelligence was gathered to inform the Cancer Alliance's approach to **primary care education** and to **public/patient facing communication** – from the perspective of the topics/issues to cover, the media to use and the need for information in languages other than English and 'easy read' versions **Actions (examples of):** Cancer Alliance to continue to support the **PCN Cancer Leads** through the Early Diagnosis work programme in 2023-4 and to ensure alignment of support from the Cancer Alliance and the locality teams. Meeting arranged for May 2023 to progress and agree details.

Cancer Alliance 2023-24 Early Diagnosis plans include continued funding for PCN Cancer Leads.

GM Cancer will explore the possibility of an online platform for PCNs to share good practice. GM Cancer will also consider scope for a more prescriptive PCN cancer lead role as plans are confirmed for 2023-24.

Action from the Oldham locality meeting to progress work between the Workforce & Education Team and the Oldham PCNs on the role of **Physician Associates** and how this could support the work of PCNs.

Cancer Alliance to continue to provide **patient, public and professional education and information** – to engage with localities to understand the topics and population groups to include. Agreement in 2023-24 to provide each locality with resource to support community engagement using GM Cancer Alliance and / or nationally developed resources.

Ongoing delivery of **primary care education** to include (but not limited to) the webinars commissioned from Gateway C – noted by the Cancer Alliance to vary the days of the week on which education sessions are held to optimise primary care attendance.

All localities agreed to continue their engagement and involvement in the GM Cancer Alliance work programmes, to ensure the Alliance work is informed by locality priorities and that the localities' cancer strategies are informed by the NHS Cancer Programme and Alliance plans. Strong locality representation on **Pathway Boards** to continue – from a provider and commissioner perspective.

Primary care colleagues in the locality visits specifically requested additional guidance on the use of the **standard referral forms and pathways** – education sessions have subsequently been arranged for PCN Cancer Leads and information shared via locality contacts. Specific education for non-clinical staff produced following the discussion in the Bolton locality, particularly in relation to FIT.

All localities were keen to see more up to date staging data – the Cancer Alliance have agreed to produce the **Rapid Cancer Registration Data** on Tableau.

GM Cancer noted the request in the HMR visit to support the development of a **chemotherapy centre in Rochdale Infirmary** and have progressed discussions on this with Christie NHS FT colleagues.

Examples of good practice:

A number of examples of good practice and proposed programmes of work were shared during the visits. Below are SOME examples of these.

Bury: well established health inequalities programme in place with wide stakeholder engagement – to take forward through the GM Cancer Alliance Health Inequalities Locality Working group to ensure sharing of good practice with other localities.

Tameside: Joint work between the CCG/locality and Tameside & Glossop ICFT on data to support cancer improvement work. Alliance BI team to pick up and replicate specific elements of this at a GM level.

Wigan: examples of strong community engagement in relation to the uptake of cancer screening programmes. Piece of work completed between the Cancer Alliance and Wigan Cancer Screening Improvement Lead (CSIL) following the locality visit. Alliance to promote via the PCN Cancer Lead network.

Stockport: the Stockport locality demonstrated a very cohesive way of working across the system between locality staff/sector, primary care and the NHS provider Trust. The close working relationships were evident. An example of how this relationship has been beneficial was demonstrated in the Quality Assurance process – a process which the Cancer Alliance will be learning from to develop a GM process.

Bolton: strong locality work in relation to the uptake of FIT in the locality – joint work between the locality and Trust staff to identify and address areas in the locality where the guidance on the inclusion of the FIT result with lower GI referrals is not being adhered to

Manchester & Trafford: Strong engagement in both localities with primary care; evidence of close working relationship with Manchester NHS FT; Manchester locality have strong relationships with the PCNs and issue detailed data packs to their PCNs to support this programme of work – Cancer Alliance to learn from the Manchester data packs to inform the Early Diagnosis Programme PCN data packs;

HMR: GM Cancer keen to take learnings from Cancer Awareness workshops in HMR and, where applicable, apply to localities across Greater Manchester. GM Cancer acknowledges the vital community work in HMR, especially engaging with disadvantaged communities to increase awareness about cancer from a prevention, screening and symptomatic perspective. The Alliance will fund Talk Cancer workshops in HMR, based on the proposal submitted to the Early Diagnosis team at the Alliance and will take learning from these into other localities.

Salford: The locality highlighted a shared interest across the system in advancing work to investigate the position on cancer diagnoses as a result of emergency attendance and to share this work with other localities via the Alliance once completed – strong clinical discussion on the value of undertaking this audit and how this might change practice in primary care and secondary care.

Title: The Christie NHS Foundation Trust
All locality visits included representatives from the local Trust. Given The Christie weren't included in the locality visits, as they don't operate with a lead/host locality, a separate

meeting has been arranged for Wednesday 24th May to discuss the Cancer Alliance and The Christie programmes of work for 2023-24.

3 Recommendation, requests / support required of the Board

The GM Cancer Board are asked to note and comment on the content of this paper and to support the continuation of this approach with a round of locality visits to commence September 2023 through to March 2024.

GM Tackling Inequalities in Cancer

Title of paper:	GM Tackling Inequalities in Cancer
Purpose of the paper:	To update the GM Cancer Board on the health inequality in cancer work programme
Summary outline of main points / highlights / issues	The following paper will update the board on the: • Redesign of the Health Inequalities Working Group • Refresh of the GM Tackling Inequalities in Cancer Strategy • Plan regarding implementation of the strategy
Consulted	GM Health Inequalities Programme Board GM Cancer Alliance Senior Management Team Matthew Evison, Associate Medical Director, Greater Manchester Cancer Alliance Alison Jones, Director of Cancer Commissioning and Early Diagnosis, Greater Manchester Cancer Alliance
Author of paper and contact details	**Name: Dan Clark** **Title: Health Inequalities Project Manager** **Email: d.clark18@nhs.net**

1 Background and Context

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. They exist as a result of systematic variation in (i) the accessibility, quality and experience of health and care services, (ii) individual behaviours and, most importantly, (iii) the wider determinants of health, such as employment, education and income[1].

There is not just a moral imperative to address health inequalities but also a financial one with health inequalities costing the NHS £4.8 billion a year in hospitalisation alone[2].

Health inequalities in the cancer system can represent themselves as differences between groups in:

- the risk of getting cancer
- the proportion of people diagnosed at an early stage
- access and experience of diagnosis, treatment, and care
- access to and representation within research
- representation within the workforce

The NHS long-term plan sets out the ambition to have a 'more concerted and systematic approach to reducing health inequalities. This has been furthered by the Core20Plus5 approach, which is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. This recognises early cancer diagnosis as one of the five clinical areas of focus for adults which requires accelerated improvement.

This strategy will support delivery of the Greater Manchester ICP Strategy and coordinated work across the system to reduce inequalities across the lifecourse to create a greener, fairer, and more prosperous city-region. This will enable the GM Integrated Care System to ensure:

- Everyone has an opportunity to live a good life
- Everyone has improved health and wellbeing
- Everyone experiences high quality care and support where and when they need it
- Health and care services are integrated and sustainable

[1] Maguire, D. and Buck, D., 2015. Inequalities in life expectancy-Changes over time and implications for policy.
[2] Asaria, M., Doran, T. and Cookson, R., 2016. The costs of inequality: whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation. J Epidemiol Community Health, 70(10), pp.990-996.

The NHS People Plan[3] cites strong evidence for promoting an NHS workforce being representative of the community that it serves, as findings suggest patient care and the overall patient experience is more personalised and patients have better outcomes. It pledges to increase diversity and inclusivity amongst the workforce which will be a key factor influencing how we achieve the ambition and especially the principles of embedding equalities through thinking inclusively.

The cancer health inequalities work in GM has been led through the GM Cancer Health Inequality Working Group which was set up in April 21 and led the development of the Greater Manchester Cancer Tackling Inequalities Strategy & Implementation Plan which was agreed at board in September 21. In September 22 GM Cancer Alliance appointed a Health Inequality Project Manager to support this work, as part of their role the Working Group decided it was necessary to update the strategy, working group and action plan which are detailed below.

2 Key discussion points

Health Inequality Programme Board
 Health Inequalities Programme Board Tc The Health Inequalities Working Group was formed in April 21, to co-ordinate partners in the GM system to address a range of issues in relation to inequalities in cancer referrals, treatment, and outcomes. The group grew over time to a membership of 52 with meetings regularly seeing over 30 in attendance. The meetings became a mix of strategic discussion, project development and project evaluation presentation. This led to meetings where we were not hearing all the voices and a lack of engagement from some members. Following a workshop held in December 2023 and with input from a range of stakeholders, the group has now moved to being a Programme Board with the purpose of: • developing and implementing a strategy to reduce health inequalities across the cancer system in Greater Manchester (GM). • sharing and building on good practice and identifying and employing a range of interventions to support narrowing health inequality in access, outcomes, and experience.

[3] We are the NHS: People plan 202/21 – action for us all. NHS England

The Board will also develop subgroups or task and finish groups on a needs basis to deliver elements of the implementation plan, groups that are already set up include:

Cancer Workforce & Education Addressing Inequalities Working Group, which will:

- strive to increase diversity within the cancer workforce through promoting inclusive recruitment practices and piloting equality interventions
- work in collaboration with key partners to promote and encourage the cancer workforce to live well
- develop tackling inequalities training in collaboration with the GM Cancer Academy to tackle inequalities to empower our workforce

Localities Cancer Health Inequalities Task and Finish Group, which was set up to:

- better understand what cancer inequalities work is happening across the 10 localities in GM
- to share any areas of good practice and where appropriate scale up and deliver across GM
- decide on locality based priorities that can be supported at a GM level
- work together to disseminate and maximise health inequalities resources and intelligence

The Programme Board will be chaired by Dr Matt Evison, Associate Medical Director at GM Cancer Alliance and supported by Dan Clark, Health Inequalities Project Manager at GM Cancer.

GM Tackling Inequalities in Cancer Strategy

GM Tackling Inequalities in Cancer

The strategy sets out how the Cancer System in Greater Manchester (GM) will tackle inequalities in incidence and outcomes and improve equity in access and experience of cancer care.

It identifies the areas in which inequalities exist in the cancer pathway and commits to high-level objectives the GM Cancer Health Inequalities Programme Board will action through a robust implementation plan and the areas the Board will look to influence in the wider GM System.

The strategy supports the principles as set out in the Greater Manchester ICP Strategy to reduce inequalities, which also incorporate those set out by the GMCVO report[4]

People Power – We will work with people and communities and listen to all voices including people who often get left out. We will build trust and collaboration and recognise that not all people have had equal life opportunities.

Proportionate Universalism – We will co-design universal services but with a scale and intensity that is proportionate to levels of need.

Health Inequalities are everyone's business – We will think about inclusion and equality of outcome in everything that we do and how we do it. Developing an institutional habit of thinking inclusively enables us to go beyond the minimum requirements of legislation and service standards, and supports universal design, creativity and innovation.

Representation – The mix of people who work in our organisations will be similar to the people we provide services for.

Health Creating Places – As anchor institutions we will build on the strengths of our communities and leverage collective power – to support communities and local economies.

The strategy focusses on the different area's inequalities exist:

Area of focus	Objective
Risk Reduction	We will work with partners to reduce the inequalities in prevalence of behavioural risk for cancer and tackle inequalities in access and outcomes to preventative programmes.
Early Diagnosis	We will work to improve equitable access to healthcare and cancer screening and reduce inequalities in signs and symptom knowledge.
Diagnosis Treatment and Care	We will work to tackle inequalities in access and experience of diagnosis, treatment, and care
Research	We will make sure our research is representative of the population of Greater Manchester and be a leader in health inequalities research
Workforce	We will work collaboratively with key stakeholders to promote 'Belonging to the NHS' focusing on inclusion and reducing inequalities within the cancer workforce.

[4] Inequalities in cancer prevention, diagnosis, treatment and care, 2022. GMCVO

GM Cancer Alliance	We will ensure everything we do at the Greater Manchester Cancer Alliance supports the reduction in health inequalities across the cancer system in Greater Manchester.

The detail of how we will achieve these objectives will be developed and tracked through the GM Tackling Inequalities in Cancer Strategy Implementation Plan, please see below.

GM Tackling Inequalities in Cancer Strategy Implementation Plan

The implementation plan for the GM Tackling Inequalities in Cancer Strategy will be developed and monitored by the Health Inequalities Programme Board and led by the GM Cancer Alliance.

The implementation plan will be focussed on the objectives as set out in the strategy and set out clear measurable actions that detail 'how' the objectives will be met. The implementation plan at present is in its infancy with the aim to have it populated with current and future projects that will help meet the objectives of the strategy by the Programme Board in Sept 2023.

The implementation plan will be a live document that will be updated at every Programme Board and will be added to as project and/or inequalities are identified. This will allow us to capture, share and monitor the great work that is being down and identify gaps where more work is needed to meet our objectives.

3 Next steps

The next step of this work is to develop the implementation plan and monitor this through the Health Inequalities Programme Board.

4 Recommendation, requests / support required of the Board

The board are asked to:

- Note the establishment of the Health Inequalities Programme Board
- Approve the GM Tackling Inequalities in Cancer Strategy
- Note the approach for the implementation plan
- Advise on how the Cancer Board would like to receive updates