

GM Cancer Board Briefing

Monday 31st March 2025

Update on announcement to National update and changes to NHS England

On the 13th March an announcement on the disestablishment of NSHE was made in association with the main announcement that the NHS has to undergo a financial reset and other cost control measures also put into place. Planning for year 25/26 in connection with this, circumstances of financial plans remain far away from control totals that are the envelope in which the overarching NHS is expected to be in. In GM the financial situation is extremely challenged, GM was expected to submit financial plan summed up to minus 200 million pounds plan for 25/26 (which is already away from a balanced position), not managed to submit a compliant plan and most recent submission is minus 295 million. Further work being done centrally to understand what GM needs to do to submit a compliant plan. Provider organisations are taking considerable measures to contend control. Function of ICB is to understand some of the spend in programmes such as the cancer programmes – to retain/save income. Expectation there will be considerable cost reduction in the planned spend for 25/26, the substance of what this means/how it will be transacted is being worked through by Cancer Alliance team to understand risks and mitigations that might be put in place to manage these activities.

Jennie Gammack added team are looking at the commissioning programmes for the next 12 months and each provider has put forward their commissioning priorities for the year and have taken a hard line this year that unless there is funding identified if it isn't already within plans then this year it will be a no as need to preserve core services. ICB wants to make a commitment to take back control and look at how we develop more robust service specifications and how we monitor against those. Also want to look at how we use our wider sector – voluntary, primary care, community etc.

ICB Update

RS summarised that much of this update was given in the previous item, JG added that commissioning intentions letters going back out and emphasised that unless already identified or in plans won't be able to fund this year. Added that from an engagement perspective, when getting to commissioning programme that Katherine Sheerin is keen to develop, it will be about future updates at this Board.

24/25 Delivery – Programme Updates

COR stated that the paper for information and spreadsheet found within the paper pack for this meeting summarises the work being done, all in green status and teams at the Cancer Alliance have done a great job delivering what has been asked for from a national perspective. About to submit first draft of the delivery plan for this year 25/26 on Thursday 3rd April.

AO Review

Clare Garnsey explained that the team have come up with a plan to save money and feel in a good position to deliver it. Shared a paper laying out at a high level what an AO transformation plan might look like as a proposal. So far have concentrated on Phase 1, need the Board's approval and members' thoughts on progressing to phase 2. Phase 1 is inclusive of equitable, timely clinical decision making in virtual pan-GM MDT, reducing length of stay and spend. Manages the complications of cancer and treatment, grouping patients in 3 broad groups. Summarised the Phase 1 system-wide daily virtual AO MDM background and current service provision - not equitable for patients. Demonstrated the pump-primed phase 1 through Cancer Alliance money, had funds transacted last year so have no funds spent from this year's budget. Have planned a comms education package for staff and patients, software in development with Christie BI team. Also done a lot of stakeholder engagement with launch taking place on 21st March. Next steps – will bring back to Board with outcomes including economic analysis. Would like permission to explore Phase 2 whilst appreciating the financial difficulties. Non-emergency metastatic strategy was pushed from agenda for today's meeting – sits within AO Plan and have a robust plan to share. Will present more fully at the next board. When it comes to Phase 2 will have a look at governance structure and bring structure and review process back to this Board.

NB asked around AO MDM – that's already costed within SLA so is that repurposing resources? And is there a logistical question as oncologists are staffing MDM? CG was transparent and explained trusts have SLA's and pay Christie for several Acute Oncologist hours that we can't deliver as there aren't enough Acute Oncologists' – but still have funding and can use this to fund, run as 3 MDT's. Current additional cost is 16 hours of a Cancer Care Coordinator to run the MDT. This is costed into Phase 1, but in terms of sustainability going



forward will try doing as much digitally as possible. Board approved the continuation and delivery of Phase 1, and development of options appraisal to in combination with the Christie and urgent and emergency care colleagues.

Dermatology Update

Developed a model of care for dermatology, by stakeholders and clinical leads from Primary and Secondary care point of view - also have input from Cancer Alliance colleagues. Proposal optimises patients' management in primary care. 2 key workstreams transacted in this part of the model; single point of access software currently rolled out across 4 localities – referrer in primary care ensures patient goes onto most appropriate pathway, transfer remainder of patients into community part of the service. Implemented GM wide procurement for the community service, evaluation hasn't taken place but should have by August this year for acute setting with providers providing community provision. Allows patients to go to community setting first and frees capacity in secondary care.

One current provider of independent sector provision has advised that they are not in a position to bid for future provision, but they are our only provider offering cancer services as part of their current specification. Will come to an end at the end of September but will shut doors early in order to clear backlog of patients in the system. Presents a huge problem in how to provide provision, working with NCA in terms of lead status provider for dermatology provision going forwards but not currently in a position due to pressures to cancer provision. Exploring possible alternative provision, meetings planned with potential providers in the next week and bringing proposal to Health and Care Service Review Board. Working on developing something for mobilisation around June, latest conversations with HCRG bringing forward a lot sooner than we had hoped. Exploring with NHSE the legalities around this as are a commissioner requested service. Have written back formally that timescales don't work for us and need to work collaboratively to manage a safe exit of that provider and backlog of patients, and what it looks like in terms of bringing on a new provider in the short term as a secondary care collaborative. In terms of lead provider model, there is a live business case with the ICB around transitional arrangements and costs and NCA becoming lead for Tameside and Stockport, what that means in terms of Wigan and Bolton working collaboratively from a dermatology secondary care provision and MFT within that. Reports on a monthly basis to Health and Care Service Review Programme Board and directly to the ICB. Drafting a brief for the TPC so they are aware more broadly.

LGD stated that given challenges over last 18 months need to think about impact it will have on service delivery and cancer patients waiting 5-6 weeks for first appointments and significantly longer than 62 days for treatment. Must understand risk in terms of psychological and harm impact, have seen harms in terms of Tameside closing and patients being diverted. Weather forecast and seasonal trend of skin cancer referrals will have a real implication on this. For NCA - when Tameside closed, they were the only provider in the vicinity and regardless of ability to manage the referrals went there – if others close, they will go to the NCA. Huge risk from a cancer perspective. LGD to be updated on a weekly basis. Cancer Board to be updated regularly. In terms of plan B, we are in conversations with MediNet whether they can help and support and linking in with Dermatology Clinical Lead to make sure appropriate clinical governance around that.

Early Cancer Diagnosis Strategy

SaT asked for approval for the strategy, people in the room already been involved in development over the last 8-9 months, and this has now gone through ED board, presented to Locality Cancer Leads, planning guidance. Strategy approved by Board.

Faster Diagnosis & Operational Improvement & Treatment Variation

LGD mentioned that there is a full paper outlining progress with each improvement initiative so can just take questions. From performance perspective we are on track to deliver interim standards for end of March, into next year currently have a compliant plan across the GM system - but not yet finalised and is in draft. RS added that performance submission may be affected by dermatology issues.

RS praised the work of LGD and the team and the achievement of being on plan to hit targets.

