

Greater Manchester Cancer Board

Minutes and Actions

Meeting time and date: Monday 31st March 2025 14:00 – 15:30

Venue: The Nest, Claverton Road, Roundthorn Industrial Estate, Manchester, M23 9TT

Chair: Roger Spencer

Members Present		
Name	Role	Organisation / Representation
Roger Spencer (RS)	Chair/Chief Executive	The Christie NHS Foundation
Susi Penney (SPe)	Medical Director	GM Cancer Alliance
Vicky Sharples	Chief Nurse Representative	The Christie NHS Foundation Trust
Claire O'Rourke (COR)	Managing Director	GM Cancer Alliance
Lisa Galligan-Dawson (LGD)	Director of Performance	GM Cancer Alliance
Lisa Spencer (LS)	GM Trust Director of Strategy representative	NCA NHS Foundation Trust
Dr Sarah Taylor (SaT)	Associate Medical Director	GM Cancer Alliance
Prof Matt Evison	Associate Medical Director	GM Cancer Alliance
Thomas Thornber (TT)	Director of Strategy	GM Cancer Alliance/The Christie
Roger Prudham (RP)	Lead Cancer Clinician representative	NCA NHS Foundation Trust
Clare Garnsey (CG)	Associate Medical Director	GM Cancer Alliance
Suzanne Lilley	Workforce & Education Programme Director	GM Cancer Alliance
Freya Driver	Programme Director for Personalised Care	GM Cancer Alliance
Susan Crabb	Answer Cancer Programme Manager	Salford CVS
Dr Ashwin Ramachandra (AR)	Associate Medical Director	NHS GM – Tameside (representing GM locality AMDs)
Sarah Keevil	Head of Financial Management	The Christie NHS Foundation Trust
Hannah Stirzaker (HS)	Strategic Lead in Cancer and Inequalities	10GM
John Wareing	Director of Strategy	The Christie NHS Foundation Trust
Neil Bayman (NB)	Medical Director Representative	The Christie NHS Foundation Trust
Jennifer Gammack (JG)	Programme Director – Sustainable Services	NHS GM Integrated Care
Sally Parkinson (SP)	Director of Finance Representative	The Christie NHS Foundation Trust



Karen Jewers	Lead Cancer Nurse	WWL
Susan Todd	Programme Director for Transformation	GM Cancer Alliance

Guests		
Name	Role	Organisation / Representation
Louise Farnworth	Pathway Manager	GM Cancer Alliance
Sophie Moore	Senior Team Administrator	GM Cancer Alliance
Sarah Carr	Senior Team Administrator	GM Cancer Alliance
Naomi Roussak	PPIE Manager	GM Cancer Alliance
Oliver Butterworth	Senior Programme Manager	GM Cancer Alliance
Dr Arasu Kuppuswamy	Clinical Director (Programmes)	NHS GM
Elaine Hodgkinson (EH)	Programme Director	GM/NCA Dermatology Transformation Programmes

Apologies		
Name	Role	Organisation / Representation
Ali Jones	Director of Cancer Commissioning & Early Diagnosis	GM Cancer Alliance
Alison Armstrong	Associate Director	GM Cancer Alliance
Dan Gordon	GM Elective Care Programme Representative	NHS GM
Jemma Woodward	Macmillan Head of Nursing for Cancer	MFT
Pippa Harper	Comms and Engagement Lead	GM Cancer Alliance
Ed Dyson	NHS GM Integrated Care Board Representative	NHS GM
Prof. Manisha Kumar	Chief Medical Officer	NHS GM
Caroline Davidson	Director of Strategy	MFT
Philippa Johnson	Deputy Place Based Lead	NHS GM
Katherine Sheerin	Chief Commissioning Officer	NHS GM
Rachel Hart	Genomics representative	NWGMISA
Rae Wheatcroft	GM Trust Chief Operating Officer Representative	Bolton NHS Foundation Trust
Nabila Farooq	Patient & Carer representative	GM Cancer Alliance

1. Welcome & Review of Meeting Summary and Action Log	
Discussion Summary	Action from the previous meeting have all been closed. No questions raised regarding the minutes and these were signed off.
Decisions, actions, and responsibility	Nil of note



2. Update on announcement to National update and changes to NHS England

Discussion Summary

RS opened the meeting by stating that all many will be familiar with challenging situation from NHS environment perspective, and outlined recent developments and what they mean for us. 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 as a whole 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. ICB and other providers doing a lot of work to understand what actions need to be done to keep spend in control, associated risks can then be managed correctly. 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. At the moment 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, the same is being done with colleagues in all programmes in GM. RS opened for any questions and noted that the Director of Commissioning was not able to attend today to answer questions.

RP raised point that the innovation of GM Cancer Alliance is shared with the rest of the country, and many have benefitted from it, and noted the value of this work. RS responded that particularly the team are looking at alternative approaches that might generate mitigation for some of the work going on, keenness that people outside of GM benefit from the work done. We will have to become more used to not adding things but replacing them – if not something that comes easily. Will come back to next Cancer Board with a bit more depth and what needs to be done to manage the situation, with risks/mitigations and opportunities.

Jennie Gammack (JG) added that last thing we want is to get to a point where we have to decommission services, 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 unfortunately this year it will be a no. Need to preserve core services. difficulty is that there is conflicting advice coming from NHSE, and part of the challenge is we have an inordinate amount of spend in the independent sector from an elective element. We have also not recovered from Covid in terms of how we contract/review the independent sector so ICB wants to



	make a commitment to take back control and look at how develop service specifications that are more robust and how we monitor against those. Also want to look at how we use our wider sector – voluntary, primary care, community etc. Welcome any thoughts as to how we get to a situation where we are not having to decommission services.
Decisions, actions, and responsibility	Nil of note

3. ICB Update	
Discussion Summary	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.
Decisions, actions, and responsibility	Nil of note

4. 24/25 Delivery – Programme Updates	
Discussion Summary	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. Will navigate through the next year which will be difficult for all across the board.
Decisions, actions, and responsibility	Nil of note

5. AO Review	
Discussion Summary	<p>CG presented from slides shared previously with members of the board in the paper pack.</p> <p>CG explained that the team have come up with a plan to save money and feel in a good position to deliver it, delivering this on behalf of Caroline Wilson who could not attend today. Have shared a paper laying out at a high level what an AO transformation plan might look like as a proposal.</p>



So far have concentrated on Phase 1 and not worked up phase 2 or 3 yet – first need the Board’s approval for phase 1 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. AO is a reasonably new specialty, with strategy coming out later this year. Manages the complications of cancer and treatment, grouping patients in 3 broad groups - type 1: diagnosed through emergency presentation. Type 2: emergency presentations with complications to treatment. Type 3: emergency presentations with complications of cancer itself.

Slide 2 of the presentation showcases the AO 5-year transformation plan overview – breaks down plan for all 3 types of patients.

Slide 3 summarises the Phase 1 system-wide daily virtual AO MDM background and current service provision. Only MFT has a 7-day service, with no cover for leave. Not equitable for patients.

Slide 5 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, good attendance from AO colleagues.

Slide 6 shows next steps- need approval/advice in terms of Phase 1 – can we continue to roll out already funded AO MDT, make sure we are suitable from a BI POV, with permission will bring back to Board with outcomes including economic analysis. Would like permission to explore Phase 2 whilst appreciating the financial difficulties.

To finish, 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 – things that can be delivered with no additional resource will continue to run.

TT queried in terms of stakeholders/engagement – what links do we have with emergency care? CG responded that they have been invited to Acute Oncology Pathway Board, but need executive level sign off to feedback through Cancer Board and Urgent and Emergency Care Board. Hope is that all senior teams working together to make sure clear oversight. TT also asked about following patient flows and feeding in from GM and Cheshire and Mersey, CG responded due to number of patients using Christie urgent ambulatory services from both trusts and oncologists cover them they come in together, if start including all Cheshire and Mersey it is hard to manage – need a way to feed into Cheshire & Mersey.

RS noted that when patients get into wrong part of the pathway, they have a poor experience and don’t have specific care. SP added it’s a missed opportunity to get



patients into the system at the right place and once they arrive at hospital it is too late. Our job is to make it more effective and more efficient. CG agreed and added that is why this must sit beside the metastatic work; Alliance has been open to this. Early diagnosis needs to go hand in hand with metastatic disease, can staff spot the signs. Want to make it further and further down the line and avoid emergency admissions.

Arasu Kuppuswamy (AK) asked how connected is it to virtual ward work? CG responded that it is not there yet as only 4 months in – have seen how amazing virtual wards can be for other non-cancer issues so adopting something that has already proven worth. Working up plan for this will be part of Phase 3. Great work out there that need to link in to.

AK also queried in terms of assessment, CG responded that in terms of MDT's AO nurses have good documentation on who patient is seen by/treatment start dates etc. and these are the most important parameters for finding delays. Will be developing health economics model alongside. If it doesn't save money or cost-neutral, then won't be BAU. Asking to introduce this and then bring back data in terms of cost and time savings.

AK then asked around advice guidance/criteria – CG answered that the Acute Oncologist position is that AO nurses are specialised, and a lot have more experience than acute medicine registrar so are leading decisions for patients.

AR questioned in terms of stakeholder, what is the governance? CG responded this needs to be considered going into Phase 2, structure was that have AO pathway board and sub-groups feed into this – feed into Cancer Board then ICB. When it comes to Phase 2 will have a look at governance structure and make sure members are happy with it. Bring structure and review process back to this Board.

RP added that if predicated on saving money then nobody will see the saving unless there is a coordinated way across the system to show how small changes make a big difference. CG responded it is difficult to get around this, can save bed days or reduce pathway but feels as if it doesn't add value to the financial situation we are in - it's about replacement services and saving days, receiving a higher quality service for patients who are often unseen as we are always looking at the front end of the pathway.

NB stated that this is an example of an innovative approach that an Alliance can take that isn't easy just from a single provider, working together and reducing inequalities in services. Need to be able to forecast measures of benefit for Phase 1,2 and 3. May or not be financial but need to be able to describe them to get the approach approved. 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 what we know, trusts have SLA's and pay Christie for a number of Acute Oncologist hours that we can't deliver as



	<p>there aren't enough Acute Oncologists' – but still have funding and can use this to fund, run as 3 MDT's. MFT and 2 in addition that have several acute trusts feeding into them – have cover for these MDT's starting with 5 days in job plans and using SLA money to pay an extra hour a day for MDT. Already in run rate for acute trusts paying the Christie. Oncologists appreciate it saves money elsewhere and streamlines.</p> <p>SPa raised concern with size of population – are we going to be taking costs out? CG replied that if we have evidence to show the savings, current additional cost is 16 hours of a Cancer Care Coordinator to run the MDT. Might be able to save this somewhere else depending on how much can be done digitally and how much is done by coordinator. This is costed into Phase 1, but in terms of sustainability going forward will try doing as much digitally as possible.</p> <p>HS added this is incredible and makes a real difference to the patients and family.</p> <p>RS summarised the ask to carry on Phase 1 and feedback for Phase 2 which will be brought to this board. Can't underestimate the alignment of activities, and advantages that can come from coordination.</p> <p>SaT added phase 2 will need a lot of input from pathways in from community and primary care.</p> <p>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.</p>
Decisions, actions, and responsibility	<p>Board approved continuation and delivery of Phase 1, and development of options appraisal. To bring back and update the board with outcomes including economic analysis.</p> <p>Metastatic plan to be presented more fully at next Board.</p>

6. Dermatology Update

Discussion Summary	<p>EH mentioned highlight report shared with papers that gives a flavour of transformation work. Been operational as a programme since August 22 and have reported into GM System Health and Care Service Review Programme Board. 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 Steph Ogden and SaT.</p> <p>Developed a proposal that optimises patients management in primary care – not all patients need to be on pathway and there are other suitable pathways. 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,</p>
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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 foremost and freeing capacity in secondary care. Currently have 27,000 patients in backlogs across GM.

In terms of System resilience, 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.

TGH service closed in October 2023, NCA supported this position and received patients from Tameside to help maintain service provision.

JG added around procurement, been competitive and transparent and means when we go live in August will have community provision for localities that haven't had it previously. Gone out for 5 lots to cover Wigan and Bolton, Trafford and Manchester, HMR and Oldham, Bury and Salford, Tameside and Stockport. Done the evaluation and moderation starts this week so is moving forward. From system resilience perspective, knew HCRG (Oldham provider) were exiting the market and started to explore conversation around what the cancer element needed to look like knowing that our acute provision wasn't in a position to support. 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.

RS raised serious concern and risk to cancer patients, need to represent risk to colleagues across the system. Situation has become more stressed than a few months ago, with escalating risks. JG agreed in terms of Oldham etc. is high on risk register if they decide to close their doors then what happens next. Have gone back and challenged their time scale of mid-April as it gives no time to do due diligence



	<p>and put an alternative in place. Drafting a brief for the TPC so they are aware more broadly. Putting significant pressure on providers with risk of tipping them over.</p> <p>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 and that will tip the service. Being pragmatic, there is a huge risk from a cancer perspective.</p> <p>SPe added can't wait until next board for an update, LGD to be updated on a weekly basis.</p> <p>RP added that this threatens performance of whole cancer system, Tameside closing was really difficult, and Oldham situation is very difficult.</p> <p>NB added that potential service closure in 2 weeks' time, and the risk has been live a long time, is there anything else we should be doing to forecast these issues and manage them? JG added risk has taken team by surprise as did originally agree an extension of contract, gone back and offered to help with waiting lists and managing routine activity but they are not in that position. ICB wrote at the end of last week and are awaiting a response. Have a meeting Thursday and will keep the board appraised.</p> <p>AR asked about options for the community across GM, SPe asked additionally what plan B after 18th April as comms would need to go out? JG responded that the worst-case scenario is 18th April closure, Oldham is engaged and present at every meeting. Very short time frame to do due diligence but will know more this week in relation to that. 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.</p> <p>SPe then questioned when going out to providers for community service, how we are to be assured this wouldn't happen again? JG responded same can be said for acute trusts, as an ICB not had rigour around contracts and performance of providers previously – will be monitoring them closely.</p> <p>SaT asked if anything is being done to stem increase of referrals, if anything can be done with GP registrars before they leave training etc. Conversion rates for skin are still very low so increased education could be done to stem this. JG has done lots of work around GP education with funding from Cancer Alliance. Part of referral process will be to help signpost alternative pathways in. SaT suggested an education package for people who are not as engaged or seeking out the education.</p>
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	<p>RS added that it seems like a bigger and more significant escalation is needed for a very difficult situation. JG responded that this has gone to Chief Officers.</p> <p>AR added need clear communication around what might happen on the 18th.</p> <p>LS stated it would be disingenuous of NCA to pick up Oldham, recognising Tameside and issues across the system. Will be choices and a range of things we can do to help, potentially a partnership solution. Have established secondary provider network where they work together looking at issues where backlog may be building in one area and making sure that organisation to put a level of resilience in, are supported across providers. Clinical team is very active in trying to find solutions whilst growing workforce and delivering sustainable solution. From Tameside perspective they are largely being seen in Salford, increase of 101% in activity (latest count). Stockport patients being seen in Altrincham which is a large amount of travel, working to get a one-stop service progressing with the ICB. As a positive, huge amount of GP education going on.</p> <p>LGD added challenge of how to manage different cohort of patients, key challenge there isn't an urgent but non-cancer pathway. Challenge from a referral and secondary care perspective as people aren't confident to step patients off on to a routine pathway as the wait isn't at the 4-week target. 27,000 routine patients in the backlog and must find a solution to stop continuous cycle of demand.</p>
Decisions, actions, and responsibility	<p>LGD to receive weekly updates on Dermatology provision and ongoing situation with Oldham</p> <p>JG to keep board apprised of upcoming meetings and response from HCRG, clear communication on potential 18th April closure.</p>

7. Early Cancer Diagnosis Strategy

Discussion Summary	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. Hope members have read through it and happy to take questions.
Decisions, actions, and responsibility	Approval given to Early Cancer Diagnosis Strategy.

8. Faster Diagnosis & Operational Improvement & Treatment Variation

Discussion Summary	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
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	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.
Decisions, actions, and responsibility	Nil of note

10. Papers for Information	
Discussion Summary	Papers were noted.
Decisions, actions, and responsibility	Nil of note

11. AOB	
Discussion Summary	RS closed the meeting, and thanked Nabila Farooq for her service as a patient representative – as this would have been her last meeting as a representative.
Decisions, actions, and responsibility	Nil of note

The next meeting is scheduled for 18th May 2025, at:
The Nest, Claverton Road, Roundthorn Industrial
Estate, Manchester, M23 9TT



Log Number	Date Created	Status (Open/Closed)	Details of actions agreed	Action Lead	Due Date	Comments
10	25/11/24	Closed	Dermatology programme requiring escalation with representation from Cancer Board colleagues.	RS/All	27/01/25	Dermatology Update 31/03/25
11	25/11/24	Closed	VS to come back to January board with an update on System Board Review/suggested constitution of Executive Committee	VS	27/01/25	
12	25/11/24	Closed	DC/RH to link in regarding access to genomic testing in the region from a Health Inequalities perspective.	DC/RH	27/01/25	Complete
13	25/11/24	Closed	DC to share Impact Report paper with membership, to go out alongside Summary & Action log.	DC	27/01/25	Paper shared with admin
14	25/11/24	Closed	Board members to give feedback on Commissioning Intentions draft.	All	27/01/25	Feedback complete
15	31/03/25	Open	Board approved continuation and delivery of AO Review Phase 1, and development of options appraisal. CG to bring back and update the board with outcomes including economic analysis.	CG	18/05/25	
16	31/03/25	Open	Metastatic plan to be presented more fully at next Board.	CG	18/05/25	
17	31/03/25	Open	LGD to receive weekly updates on Dermatology provision and ongoing situation with Oldham	LGD/JG	18/05/25	
18	31/03/25	Open	JG to keep board apprised of upcoming meetings and response from HCRG, clear communication on potential 18th April closure.	JG	18/05/25	





Greater Manchester
Cancer Alliance

