Greater Manchester Cancer Alliance Delivery Plan Template 2025/26

Part 1 – Narrative Plan

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# How to use this template

**There are two parts of the delivery plan template:**

PART ONE - This word template for narrative plans

[PART TWO](https://future.nhs.uk/canc/view?objectId=240247781) - An Excel template for; finance allocations, data trajectories, milestones, risk register. This part should also be used to add any supporting information required by regions in relation to provider improvement plans.

**Purpose of the planning templates:**

The national team of the NHS Cancer Programme develop these templates to support Cancer Alliances to submit clear plans which address the key requirements for cancer delivery for the year ahead. These templates should be completed together, in full, to form the Cancer Alliance delivery plan 25/26.

Completed templates are used by regions to assure the Alliance’s delivery plan and form the basis of the Cancer Alliance funding agreement which accompanies the release of cancer service development funding to the Alliance (via the Lead ICB).

Alliances may be asked for some planning information through other means e.g. expressions of interest for pilots. But the Part One and Two planning templates represent the primary route through which Alliances can collectively set out their approach to address cancer improvement priorities across each of the following areas; operational performance and faster diagnosis, early diagnosis, treatment and care.

Progress updates against delivery plans will be requested via a Cancer Alliance quarterly reporting template, such that regions can assure delivery and use of funds accordingly.

**PART ONE - Cancer Alliance Narrative Plan**

Please ensure that all narrative plans;

* are written with direct reference to the deliverables in the [Cancer Alliance Planning Support Pack](https://future.nhs.uk/canc/view?objectId=240247109), and in response to any specific prompts (see italicised in each section);
* reference activities to address health inequalities;
* explain how the allocated funds from your cancer service development funding (per the amounts set out in the finance tab of Part two) will be used;
* are representative of delivery at an Alliance-level i.e. not separate system-level plans.
* can be appropriately resourced within reasonable timeframes which do not back load activity into Q4.
* Are clear and to-the-point. Programmes which have been categorised 1 (locally led) or 3 (delivered through partners), only require brief narratives unless specified otherwise.
* Complete all peach spaces (unless it is a targeted programme or pilot that your Cancer Alliance is not running, in which case mark as N/A). Grey boxes are optional.

# Timeline

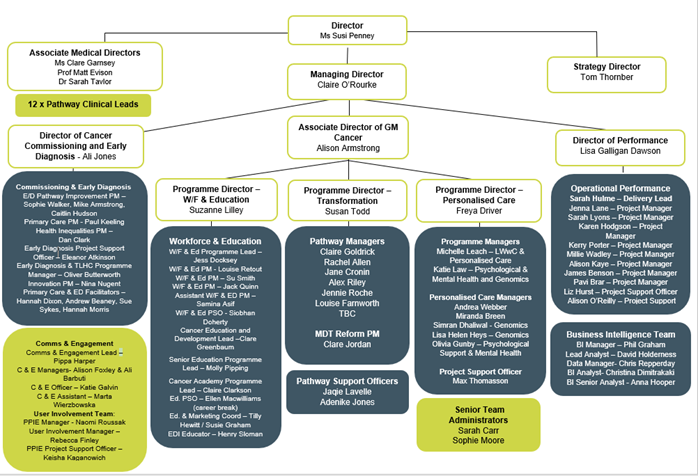
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| **Action** | **Timing** |
| Publication of Operational Planning Guidance | 30-Jan |
| Publication of Cancer Alliance Interim Planning Support Pack | 06-Feb |
| Headline system submission | 27-Feb |
| Publication of Cancer Alliance Planning Support Pack | 07-Mar |
| Alliance plans submitted (**Operational Performance, faster diagnosis priority pathways, FIT and local early diagnosis elements of templates 1 & 2 only)** | 7-Mar |
| Feedback provided to Alliances, via regions, to support submission of final system plans | 19 Mar |
| Full system plan submission | 27-Mar |
| Full Alliance plans submitted (to include all details in response to the full version of the Cancer Alliance Planning Support Pack) | 3-Apr |
| Feedback on full Alliance plans provided to Alliances, via regions | Late April |
| Regional signoff of plans (unless additional steps required by Alliances to finalise plans) | End April/Early May |
| Funding agreements released for approved Alliance plans | May |
| ICB Compacts signed | 9-May |

# Cancer Alliance Key Information

Name of Cancer Alliance: Greater Manchester

Key contact name & email: Claire O’Rourke - Claire.orourke2@nhs.net, Alison Armstrong – Alison.armstrong7@nhs.net, Lisa Galligan-Dawson – lisa.galligan-dawson@nhs.net, Alison Jones – Alison.jones8@nhs.net

Please upload your Alliance’s most recent team organogram. This is useful context to understand how plans will be delivered.



# Cancer Alliance Delivery Plan 25/26

## 1 Workstream: Faster Diagnosis and Operational Performance

### 1.1 Operational Performance

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| **Deliverables:**   * Develop and deliver an Operational Performance Improvement Plan which will contribute to an improvement in Cancer Waiting Times performance across the three standards: Faster Diagnosis, 31 day Decision to Treat to Treatment and 62 day Urgent Referral to First Treatment Standards * Plans should be clearly related to work on Faster Diagnosis pathways where relevant, alongside staging and treatment elements of the pathway and should include a particular focus on:   + Improvement plans for tumour types where an ICBs 62 day performance is in the bottom quartile compared to other systems, in Q3 2024/25, (or below 50%)   + Actions to address where >25% of patients are waiting more than 31 days for treatment on a pathway at a provider (e.g. Prostate Surgery) using Q3 2024/25 as a baseline.   + The lung 62 day pathway performance, including the staging and treatment phases of the pathway.   + Overcoming seasonality to support more consistent performance across the year, including a continued focus on skin performance in providers where FDS skin performance was below 75% within individual providers in 2024/25 (from April to September 2024) |

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

*Please reference provider performance improvement plans and timelines for implementation where performance falls below threshold, and any projects which promote the national CWT guidance.*

*Plans do not need to duplicate details on priority pathways under the Faster Diagnosis section of the planning template, but should reference and draw clear links to that work where relevant.*

*Please do not include any performance data/graphs/tables.*

GM Cancer Alliance has an established dedicated team encompassing a Director of Performance, who has direct relationships with the ICB operational performance team, other system groups, Trust Provider Collaborative team, Chief Operating Officers (COOs) and Executive Medical Directors (EMDs). There is a delivery lead, and 7.4 WTE project managers and 2 support officers supporting FDS, OP and TV. The Cancer Alliance Business Intelligence and data function also sits within this portfolio. The DoP is supported by an Associate Medical Director with the same portfolio.

An improvement plan is designed which primarily focuses on delivery of the 62 day pathway, encompassing diagnosis, staging and treatment stages (and thus FDS). Targeted support to 31 day performance for sub treatments will be included, but primarily the focus will be on first treatment, within the 62 day pathway. The draft plan has been shared with the lead COO and ICB Performance Director. The plan will go through wider stakeholder engagement prior to being finalised. Component elements are:

* Skin - Tele-dermatology, proactive peak demand preparation, comms to drive out of ‘season’ referrals
* Cross tumour optimisation of triage, deep dive pathway analysis and targeted optimisation, surgical work up and optimisation project
* Single Queue Diagnostics programme – expansion
* Cancer Treatment Optimisation Clinic – Launch OG and develop Uro-pelvic
* Radiotherapy – NW improvement role and local pathway re-design
* Supported and facilitated attendance projects
* Gynaecology – HRT pathway, ovarian one stop and hysteroscopy improvement projects
* Urology – Nurse led LAPT, bladder one stop, TURBT clinical prioritisation project
* Lung – PET and reflex testing pathways

In addition to the key areas above, there are a number of projects continuing into next year, which include H&N and improvement work regarding reducing inadequate samples, consolidation of oncology clinic booking and scheduling to reduce variation, along with work across the GM system with other system groups such as elective – SPOA project, CDC optimisation, digital pathology etc A detailed action plan is created, and each project will be tracked. The detailed plan can be shared.

A performance improvement ‘ready reckoner’ is in place by tumour site and Trust. This reviews the last three months data (rolling update) and enables calculation of ‘average’ days to be saved that would move the number of patients to compliance to enable performance delivery. The latest data has been used to inform the plan.

The improvement plan will be monitored through the FDS, Operational Performance & Treatment Variation Programme Board arrangements, which links directly with GM COOs, EMDs and the ICB. Delivery objectives and financial spend will be monitored through the GM Cancer Alliance Programme Assurance Group and upwards to the GM Cancer Board.

Trusts will be supported to develop their own plan based on these overarching objectives and in line with the GM priorities, and these will be assessed and agreed. Monitoring of provider plans and delivery will be tracked at scheduled intervals, with frequency determined by progress and risk.

Monthly delivery groups are in place with tumour specific focus, peer support, sharing of improvement work and challenges. These are well attended by the improvement teams in each Trust and provide spotlight focus. The monthly cancer manager forum continues, with fortnightly ‘protected time’ to discuss key issues or escalations between meetings.

Performance by tumour site is reported through each of the 12 tumour specific pathway boards (PWB), and dedicated actions pertaining to pathway improvement will be included in each PWB action plan. A number of clinical 0.5PA’s will be recruited to in April to provide dedicated clinical support.

A GM IPT policy is in place and will be reviewed upon the launch of CWT V12.1. A draft system-wide access policy will also be finalised at this point.

*How you plan to address Health Inequalities as part of this work (optional)*

Health Inequalities is a golden thread throughout the work programme, with data driven plans for improvement focussed on reducing variation. The BI team has developed a suite of reports to look at the different CWT metrics through an inequalities lens (sex, IMD decile, ethnicity etc). This allows us to target interventions. In addition specific actions have been included around the ‘facilitation’ of access to appointments and patient communication materials.

### 1.2 Faster Diagnosis: Priority Pathways (Urological Cancer)

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| **Deliverables:**   * Rollout training for non-medical LATP biopsy for suspected prostate cancer with a minimum of one trained non-medical staff for all providers by Q4 2025/26 * Expand the focus beyond prostate cancer to include kidney and bladder pathway performance, identifying opportunities to optimise referral practice and establish one stop haematuria services * Identify delays using pathway analyser tools and assess reasons for variation in FDS and 62 day performance, including gaps for cancer vs ruled-out patients. Put improvement plans in place by Q2 including triage models for providers with FDS performance in the lowest quartile (excluding tier 1 providers who have already provided plans for recovery) |

**Name and email of Cancer Alliance Lead Contact**: Lisa Galligan-Dawson lisa.galligan-dawson@nhs.net & Sarah Hulme sarahhulme1@nhs.net

**Narrative plan for 25/26**

*Please set out the current position and an improvement plan for each objective for urology, for example, provider-level plans to increase the number of non-medical staff trained and supported to undertake LATP biopsy, or provider-level plans for where one stop haematuria clinics will be implemented.*

*Please include an outline of pathway improvement work across the Cancer Alliance including prostate, bladder and kidney cancers, including a particular focus on providers who should complete a pathway analyser and planned dates for completion.*

A continued programme of work is in place to train staff through the Edge Hill. Each Trust has got individuals already completed training or going through training and competency to aid delivery of the ‘each trust having training staff in place by Q4’. Currently 4 nurses are delivering LATP, with varying levels of autonomy. 2 have completed the course and are being supported in the workplace, and 4 others are completing courses currently. Securing dedicated lists, and mentoring has been a key challenge and a focus for this years work, with mentoring processes and plans developed with the PWB. Subject to course availability and mentoring the Cancer Alliance will continue to support training places.

A bladder improvement group is in place across GM with an action plan in place which includes developing one stop bladder, TURBT clinical prioritisation. A pilot on the TURBT clinical prioritisation has commenced, and this will be assessed for further expansion.

GM Cancer has received confirmation that the Alliance has been selected to participate in the national ‘Pi’ Prostate MR AI project. Details are not yet confirmed, but this will support the prioritisation of high risk MR reports for early identification for reporting, and a phase 2 pilot on MR and biopsy prior to day 7 of the pathway.

The wider action on triage optimisation will include all urology cancer types.

Deep dive work will continue to inform local action plans. The key improvement initiatives are LATP – To launch in SQD, and the development of the uro-pelvic CTOC given the most significant factor in delivering 62 day performance remains with ‘All option’ prostate patients.

MFT is within the bottom quartile FDS in Urology. There is already an action plan in place for improvement and the Cancer Alliance is supporting delivery. The Cancer Alliance is leading on the deep dives into pathway non-compliance to continually inform the improvement plan. GIRFT have been approached to provide external clinical support.

*How you plan to address Health Inequalities as part of this work (optional)*

Tumour specific data in place to inform improvement work and drive reductions in variations. This will be used to review impact of interventions

### 1.3 Faster Diagnosis: Priority Pathways (Gynaecological Cancer)

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| **Deliverables:**   * Complete the rollout of Unscheduled Bleeding on HRT pathways to all eligible providers by Q2 2025/26 and utilise local evaluation/audit findings to optimise and transition to BAU for all live services by March 2026 * Identify delays using pathway analyser tools and assess reasons for variation in FDS and 62 day performance, including gaps for cancer vs ruled-out patients'. Ensure improvement plans are in place by Q2 including clear triage models for providers with FDS performance in the lowest quartile (excluding tier 1 providers who have already provided plans for recovery) |

**Name and email of Cancer Alliance Lead Contact**: Lisa Galligan-Dawson lisa.galligan-dawson@nhs.net & Sarah Hulme sarahhulme1@nhs.

**Narrative plan for 25/26**   
*Please include context on unscheduled bleeding on HRT implementation status and update on how this service will be implemented (if not already), including a go live date, the proposed model to be implemented, and plans for evaluation/optimisation.*

*Also include an outline of pathway improvement work across the Cancer Alliance, including a particular focus on providers who should complete a pathway analyser and planned dates for completion.*

GM has a primary care HRT pathway in place across GM. The focus of the 25/26 plan is the audit and optimisation of this pathway. A programme of GP education is in place and will be targeted where needed to individual PCNs and practices. Audit will commence in Q1, with actions on compliance and areas of optimisation from Q2 onwards.

A programme of on-site Trust work is in place focussing on FDS step off, deep dive, improvement opportunities and includes three key areas of improvement. Hysteroscopy – reduce the ratio of OP to IP to ‘best in area’. Improvement to patient information and procedure experience - preparation for procedures and addressing the devaluing of female pain and thirdly, ovarian one stop expansion following a successful pilot and as presented nationally. To be agreed at forthcoming Pathway Board meeting.

Deep dive work will be completed in Q1 with Trust by Trust improvements in place from Q2.

Optimising triage is a cross cutting theme in operational performance, including gynaecology. This will review a non-clinical triage model.

Tameside has gynaecology FDS in the bottom quartile, and support will be provided to the trust to address local issues as part of their improvement plan. The clinical and operational teams are engaged already.

*How you plan to address Health Inequalities as part of this work (optional)*

Tumour site data in place to drive improvement targeted at reducing inequalities and variation as well as improving performance.

### 1.4 Faster Diagnosis: Priority Pathways (Breast Cancer)

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| **Deliverable:**   * Complete the rollout of breast pain Pathways to all eligible providers by Q2 2025/26 and complete transition to BAU for all live services by March 2026 |

**Name and email of Cancer Alliance Lead Contact**: Lisa Galligan-Dawson lisa.galligan-dawson@nhs.net & Sarah Hulme sarahhulme1@nhs.net

**Narrative plan for 25/26**

*Please include context on breast pain only service status (not started, planning, mobilisation, live, BAU) for each named provider, and should include an update on how this service will be implemented (if not already), including a planned go live date, the proposed model to be implemented (virtual telephone clinic, face-to-face clinic in hospital, face-to-face clinic in community, or GP led clinic), and plans for evaluation/optimisation.*

*Also include an update on provider improvement work for suspected breast cancer pathway, particularly where the provider has challenges in the pathway, and should also provide the expected delivery dates / key milestones for improvement work.*

Each GM provider has a mastalgia pathway in place. This is funded externally presently using extended GP roles. This has been a clear success in managing mastalgia patients coming into secondary care through telephone assessment. However, a programme of education work has significantly reduced breast pain referrals into secondary care and thus capacity initially created is not specifically needed for this patient cohort.

Given the expected changes to CWT V12.1, the management of breast symptomatic patient referrals is expected to change, where Advice and Guidance can be provided as an alterative, further reducing the volume of patients coming into secondary care. Assessment of opportunities will be undertaken following the release of CWT V12.1

*How you plan to address Health Inequalities as part of this work (optional)*

Tumour specific information available to include in the review of opportunity following the release of CWT V12.1

### 1.5 Faster Diagnosis: Priority Pathways (Skin Cancer)

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| **Deliverables:**   * Complete the rollout of teledermatology to over 50% of USC referrals in all applicable services. Optimise teledermatology pathways to achieve benefits realisation and ensure services have BAU funding mechanisms in place by Q2 * Expand opportunities for nurse roles and one-stop surgery on the skin pathway to improve dermatologist capacity |

**Name and email of Cancer Alliance Lead Contact**: Lisa Galligan-Dawson lisa.galligan-dawson@nhs.net & Sarah Hulme sarahhulme1@nhs.net

**Narrative plan for 25/26**

*Please include updates on the rollout of teledermatology services, particularly how services that are still to be embedded (>50% uptake) will increase their uptake, including expected go live/expansion dates, and plans to optimise services (e.g. image taking and review training).*

*Indicate any planned actions to expand nursing roles, improve links with plastics and implement one-stop surgery.*

The GM Tele-dermatology programme supported the implementation of secondary care tele-dermatology across GM and NHSE funding was secured to support the roll out of Skin Analytics in all GM sites through a combination of phase 1 and 2 funding.

Funding expires for our two main Trusts in May 25, but given the lack of NICE approval for autonomous read, it is not possible to generate a business case for change that demonstrates a return on investment.

The focus for the Cancer Alliance will be to negotiate an extension to the Skin Analytics contract for these two providers to align with the remainder until end Q3 (and to include a second read) in anticipation of a NICE announcement. This will support Trusts to write and demonstrate the case for sustained investment from Q4 (or to remove skin analytics platform).

Priority work remains to optimise both the use of the system (volume of referrals through) and acting upon the results generated. A comprehensive evaluation plan is also in place and data collection commenced.

One stop models are in place in two organisations across GM. Work programme plans will focus on exploring opportunities for expansion and optimisation.

*How you plan to address Health Inequalities as part of this work (optional)*

Tumour breakdown of performance date will be used, particularly to understand any potential inequalities related to AI / tele-derm

## 2 Workstream: Early Diagnosis

### 2.1 Faecal Immunochemical Testing (FIT)

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| **Deliverables:**   * 80% of LGI urgent suspected cancer referrals to be informed by a FIT result * Fewer than 20% of colonoscopies on the LGI urgent suspected cancer pathway to be performed without a FIT result available * Minimise the number of colonoscopies performed on the urgent suspected cancer route in patients with a FIT result <10u/gm, normal full blood count and normal examination * Support all endoscopy providers to move to the most up to date National Endoscopy Database schema, NEDi2.1 |

**Name and email of Cancer Alliance Lead Contact**: Mike Armstrong Michael.armstrong4@nhs.net

**Narrative plan for 25/26**  
*Please include:*

* *Plan to support PCNs not yet at 80% against CAN04, to reach this milestone*
* *Plan to support secondary care providers to triage LGI referrals and maximise the number rerouted or discharges with FIT <10, normal examination and FBC*
* *Primary and secondary care support to implement protocols to remove FIT negative patients with no ongoing clinical concerns from the LGI FDS pathway*
* *Plan to improve data completion for 2 Cancer Alliance success measures, where relevant*
* *Plans to upgrade all sites not using the schema i2.1 for NED*

GM is now over 80% against the CAN04 metric as a region. To ensure continued improvement, we will look to target practices that remain under that value through our Primary Care Facilitators (PCFs). The PCFs, have already developed relationships with our PCN Cancer leads, and will use the available data to identify practices and support them to correct any data quality or process issues. In addition, the already established Early Diagnosis of Colorectal Cancer Task and Finish group will continue in to the new year, with ongoing support from dedicated clinical lead and project manager. The purpose of this group is to scope, implement and evaluate interventions that can increase early diagnosis, including FIT uptake and compliance. Planned work for this group includes:

* The continued management of our This Van Can, community outreach project, until it comes to an end in April.
* To explore a pilot FIT direct to referral pathway from within labs, allowing positive FIT samples to be referred direct from labs to secondary care without the need of additional GP input.
* To work with VCFSE and community groups to co-produce and/or build upon existing educational assets to continue the core messaging from the This Van Can project beyond the end of the roadshow. This will focus on engagement with communities who may be unlikely to engage with the van.
* To support a PhD project exploring FIT performance in Young Adults
* Primary Care education events

In addition, through the Pathway Board and Imaging network we will continue to support secondary care providers in achieving/reducing the FIT negative metrics alongside the implementation of NEDi2.1.

*How you plan to address Health Inequalities as part of this work (optional)*

As above, we plan to work closely with VCFSE organisations and our communities to develop and build upon, bespoke educational assets that are specific and appropriate for communities who experience health inequalities. We hope that using the momentum from our ongoing community outreach project focusing on symptomatic bowel cancer will enable us to to create a more lasting impact.

In addition, we will use locality data to inform a targeted approach to interventions where appropriate. Building on local work that explored how inequalities effected FIT return rates and probability of returning invalid tests.

### 2.2 Lung Cancer Screening Programme

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| **Deliverables:**   * Invitations, Lung Health Checks and CT scans (incident, prevalent & nodule surveillance) to trajectory. * Increased uptake of LHCs to above 58% (in year), and maintenance at that level, and maximise coverage of follow-up CT scans for those who qualify. * Prepare for national patient level dataset and ICT system implementation * Minimise the reporting rate of non-clinically significant incidental findings, with a particular focus on mild CAC, in line with updated Incidental Findings Protocol. |

**Name and email of Cancer Alliance Lead Contact**: Oliver Butterworth oliver.butterworth2@nhs.net

*Lung Cancer Screening Programme assurance will be based on trajectories and 100% rollout plans collated separately. There is no requirement to write a separate plan.*

### 2.3 Hepatocellular Carcinoma (Liver) Surveillance

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| **Deliverables:**   * Finalise implementation of a call/recall system to track and invite those eligible for 6 monthly liver surveillance by the end of Q2. * Support liver services to invite >80% of patients with Hep B/cirrhosis/advanced fibrosis to 6-monthly ultrasound surveillance and support >60% of those invited to attend. * From Q2, work with the ICB(s) and/or local CDC(s) to develop plans to transition the commissioning of liver surveillance services to the relevant ICB(s) in 26/27. |

**Name and email of Cancer Alliance Lead Contact**: Sophie Walker, Pathway Improvement Project Manager, [s.walker21@nhs.net](mailto:s.walker21@nhs.net)

**Narrative plan for 25/26**  
*Please include:*

* *Plans and timelines for implementation of call/recall system by each provider.*
* *Plans to support liver services to invite >80% of patients with Hep B/cirrhosis/advanced fibrosis to 6-monthly ultrasound surveillance and support >60% of those invited to attend (including plans on data collection from all providers, staffing and ultrasound capacity, compliance with HCC surveillance minimum standards).*
* *Plans and timelines for transitioning commissioning to ICB*(s)

Continue to fund Hepatology Navigator posts in each provider to support the delivery and admin of liver surveillance.

Continue to fund Hepatology Nurse to continue recently implemented nurse led liver surveillance service in Tameside & Glossop Integrated Care NHS Foundation Trust.

Work with hepatology teams and radiology teams to embed liver surveillance codes and reporting template. This will support using existing radiology systems as the digital recall solution where other options do not exist. Tameside and MFT will integrate a recall system into their existing electronic patient records in Q1, and we will look at replicating this across other Trusts in Q2 and Q3.

Bolton NHS FT – plan to use existing radiology system to embed US code. Plans to perform an audit to assess use of liver surveillance specific code. Outpatient scans currently requested on paper but moving to electronic requests in Q2.

WWL – protocol for automatic recall already in place. Plans to move this protocol from excel spreadsheet to existing radiology system in Q1 whilst request to EPR development team is pending. Previous EPR change requests have been rejected so this may be a risk.

Northern Care Alliance – plans to change EPR to EPIC in the next few years, so the Trust will replicate the liver surveillance forms developed by MFT. Meanwhile, lead radiologist is implementing liver surveillance US code to support tracking patients in radiology systems in Q2.

Stockport NHS FT – currently use excel spreadsheet to track patients. Plans to meet radiology leads in Q1 to embed liver surveillance code to enable tracking and recall within radiology systems. This will likely be implemented in Q2.

MFT – Liver surveillance form is being developed in EPIC. Navigator is compiling lists across multiple hospital sites in Q1 to create one master register and integrate into EPIC. This will ensure all liver surveillance patients are coded appropriately. Full integration into EPIC with automatic recall enabled will take place in Q3.

Tameside IC NHS FT -  Fibroscan pathway redesigned to ensure appropriate patients are identified for liver surveillance. This will be implemented in Q1. PTL will be created in existing EPR to track and recall patients for liver surveillance, plans to go live in Q1.

Support navigators to report data from all Trusts by end of Q1.

In Q2, begin discussions with relevant ICB colleagues to support transition to business as usual, through presentation of business cases at local commissioning oversight meetings.

*How you plan to address Health Inequalities as part of this work (optional)*

The patient information leaflet has been developed in both paper and digital formats to improve access to information. This can be translated into multiple languages and easy read where required.

## 3 Workstream: Local Early Diagnosis

### 3.1 Local Early Diagnosis Plans

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| To support the development and delivery of a coordinated, need-led local early diagnosis plan for each Alliance, please use this section of the template to outline the system(s)-level targets, priorities, and related interventions for your area.  **A: ICB-level ambition for improving rates of earlier diagnosis:**   |  |  |  | | --- | --- | --- | | **ICB name** | **ICB early diagnosis baseline** *(Early diagnosis baseline should be September 2024 12-month early diagnosis rate,* [*Rapid Cancer Registration Dataset*](https://digital.nhs.uk/ndrs/data/data-outputs/cancer-data-hub/rapid-cancer-registration-data-dashboards)*)* | **ICB 25/26 Target** *(Early diagnosis target should be provided per ICB, as %point increase, based on a 12-month rolling average Rapid Cancer Registration Data. Targets should reflect the impact of national and local activity that will be delivered within the ICB.)* | | Greater Manchester | 58.6% | The GM 12-month rolling average in September 2023 was 56.7% which illustrates a 1.9% point improvement over the 12 months September 2023 – September 2024.  The ICB 2025-6 target for Greater Manchester is a further 3%point improvement, to reach a minimum of **61.6%** by 31st March 2026. |   **B. Priorities and underpinning rationale**  Please briefly state your Alliance’s priorities for improving earlier diagnosis and outline the underpinning data-led rationale. Priorities could be; tumour sites, geographies (PCN/ICB) and/or communities. This should focus on any outliers or worsening trends in earlier diagnosis, tumour sites with a high volume of late diagnoses and areas of high deprivation, in line with Core20PLUS5 and with reference to recent trends in Rapid Cancer Registration Data (based on 12- month rolling average data). CancerStats2 Rapid Registration Data download has been provided to assist analytical work. Please note, not all tumour sites are included within the Rapid Cancer Registration Dataset; Full Registration and other data sources should also be considered   |  | | --- | | *EXAMPLE:*  ***Priority 1: Lung cancer.*** *Lung cancer early diagnosis rate for X Alliance is 35.5% (Sept 2024 12-month rolling average, RCRD), this is below national average of 39.6%. There is a 4%pt early diagnosis gap between X ICB and Y ICB in the Alliance. Lung cancer has the highest volume of late stage diagnoses by tumour site in the alliance, equating to 1800 late stage diagnoses per annum. Lung cancer rates are more than 2.5 times higher in the most deprived fifth of the population compared with the least deprived. Within X ICB (where early diagnosis rates are lowest), routes to diagnosis data shows that emergency presentations are 2%pt higher across the ICB and the referral rate is 5%pt lower compared to the England average. Our approach for this priority is take forward interventions to improve primary care referrals, increase access to diagnostics and improve public symptom awareness within X ICB.*  ***Priority 2: etc…*** | | **During 2024-5 the GM Cancer Alliance led a system wide programme of work to develop the GM Strategy for Early Cancer Diagnosis 2024-2028 with the following vision:** Our vision for the people of Greater Manchester is a future where everyone with cancer receives equitable and timely early diagnosis. By raising public awareness, reducing health inequalities, and fostering collaboration and innovation, we aim for continuous improvement to the proportion of cancers diagnosed at an early stage.  We have 5 foundations and 5 priorities for 2025-6. Our foundations are:   * **Data and evidence at the core of decision-making** * **Identifying and tackling health inequalities** * **Targeted, clear, and diverse communication** * **Collaboration and Co-Design** * **Empowered and enabled people and teams**   **Our priorities are:**  ***Priority 1: Symptom Awareness***  The Cancer Alliance will lead a programme of community engagement work focused on the pathways referred to in ‘priority 2’ below plus work on generic cancer signs and symptoms and a wide-reaching ‘primary care is open’ public and patient facing communications piece. Our engagement work will be based on the strong community, place based and primary care relationships we have and will ensure the development and sharing of assets to support these conversations. We will extend our mobile community outreach work using the well developed ‘This Van Can’ strapline. This will be a full 12 month mobile outreach project covering a range of different topics and moving around the whole of Greater Manchester, with locations based on the areas identified as those where we see the lowest levels of early stage presentation.  In addition, we will ensure a presence at events where there is significant footfall and / or in specific locations that have been identified as warranting targeting, linking with our community training and education.  We have allocated funding to commission the CRUK Talk Cancer sessions which have been very well received in GM over the past 2 years. This will include the workplace sessions, delivering messages to the largest employers in the 10 localities.  ***Priority 2: Reduce Variation***  We have identified 6 pathways through our strategy work where we will focus our efforts in 2025-6. The rationale behind this decision is as outlined below.  **Gynaecology:** RCRD September 2024 shows GM 18th of 20 Cancer Alliances at 63% early stage. Only 33% for ovarian (19th of 20).  **Head & Neck:** Published staging data and our GM work on inequalities has identified significant variation across GM hence approving this as a priority for 2025-6. We have recruited clinical support from primary care (dentistry) and secondary care to support this work.  **Lung:** 2nd against other 20 Cancer Alliances BUT still only 47.2% stage 1 and 2 in a high volume pathway with poor outcomes in GM  **Lower GI/Colorectal:** High volume speciality with only 47% early stage diagnosis. Aligns with additional work on FIT as per planning guidance. Significant joint opportunities between symptomatic and screening diagnoses.  **OG:** We are a significant outlier from a national benchmark perspective and it’s one of the lowest % early stage of all tumour sites in GM.  **Pancreatic:** We have had a significant amount of interest in primary and secondary care in improving the pathways for pancreatic cancer and it’s a pathway where we know there are significant improvements we need to and can make, through strong clinical leadership and membership of our pathway board.  **Locality Variation:** RCRD shows that we have variation across our 10 localities ranging from 53.2% to 59.9% (12-month rolling average May 2024). Our 10 localities have all committed to the production and delivery of place level plans for early cancer diagnosis in 2025-6.We have established a process with our Integrated Care Board to ensure Early Cancer Diagnosis is a metric included in the Locality Assurance Meetings which are led by the ICB Performance and Delivery team. This enables us to have senior exec level conversations in ‘place’ to challenge the position in terms of stage at diagnosis and the delivery of a locality level plan to address this.  ***Priority 3: Collaborate with Primary Care***  In 2025-6 we will build on the work done during 2023-24 and 2024-25 with primary care colleagues in Greater Manchester.  The Cancer Alliance will continue to utilise standardised referral templates and will be assessing their utilisation to ensure that referrals are appropriate and are accompanied by patient information and relevant investigations. Feedback (both on request and by referrers when making referrals and as part of system quality improvement), a continuing programme of training and education, access to and use of management tools (such as safety netting and clinical decision support tools, CDST) will be supported and offered via the Cancer Alliance and Partners to ensure the continued streamlining of referrals.  Engagement with the offer by primary care will continue to be the core component of the Primary Care and Early Diagnosis Facilitator programme aimed principally at PCNs - we will be extending the programme to include other sectors of primary care over the coming year. The programme also aims to support the local delivery and implementation of quality improvement schemes of work (including targeting of underrepresented communities), shared learning and collaboration that will contribute to the further streamlining of referrals and potentially a reduction in presentation via other routes (e.g. as an emergency) and that will extend the reach of primary care through improving accessibility, efficiency and integration.  The designated cancer leads in each of the PCNs across Greater Manchester have provided an invaluable resource through which to channel our offer via the Facilitators and through which we receive feedback. We will continue to support these roles going forward with a small grant which has been used to develop, deliver and implement PCN early cancer diagnosis action plans – all PCNs returned a plan in 2024/25 which has been used to track progress against the stated aims in the action plans and an overall improvement in the quality and delivery of those plans has been observed.  To ensure that the work we undertake has the appropriate focus and to maximise engagement for primary care colleagues we will be working with representatives of all sectors of primary care and relevant secondary care to support the training and education programme - which will for this coming year have a greater focus on community pharmacy and dentistry – and for which we have an annual plan to include: annual one-off full day Early Cancer Diagnosis event; 4 cancer type specific face to face events ; 12 topic specific webinars with post-event assets to share with non-attenders.  GM Shared Services will continue to support the development of our ‘Think Cancer’ CDST for general practice and will support the loading and use of standardised referral forms together with providing capacity to deliver searches and continued improvements to practice level data.  We will continue to promote the assets provided via GatewayC and as part of our annual education strategy will utilise the expertise and digital platform of the GM Cancer Academy who will be assisting in the delivery of this element of the work programme.  There is an evidence base to support staff training and education as part of a wider programme of work that includes improving accessibility, service improvements, collaboration and the targeting of underrepresented communities as part of a programme of work to improve the early detection of cancer.  ***Priority 4: Cancer Screening and NHS Wide Programmes***  We are already successfully delivering several NHS England specified programmes and realising the benefits of these for our population.  Unfortunately, uptake of cancer screening programmes is lower in Greater Manchester than elsewhere. Although there has been improvement in uptake for the bowel cancer screening programme following the introduction of FIT in 2019, we have seen a reduction in the proportion of eligible people participating in the breast and cervical screening programmes, both nationally and locally in Greater Manchester over the last 8 years.  There are several reasons behind this, some related to individuals’ awareness of eligibility criteria while others related to perceived barriers. Understanding and tackling these barriers, as well as direct efforts towards improving people’s understanding of screening programmes and eligibility criteria, will act as a key lever in improving early diagnosis rates for breast, bowel, and cervical cancer.  The NHS GM Screening & Immunisation Team is developing a focussed programme of interventions to improve the delivery and uptake of breast screening. Specifically, they have developed targeted interventions, such as text messaging reminders, collaborations with local GP practices, and community outreach initiatives, to increase screening uptake.  Additionally, the Screening & Immunisation Team are working with provider organisations to ensure that the bowel cancer screening programme is expanded to eventually invite people between 50 – 74 years.  ***Priority 5: Innovation***  Innovative practice is key to staying at the forefront of early cancer detection and is a vital element to our plans to achieve the 75% ambition. We need to identify and develop innovative ideas, establish Greater Manchester as the leading place for pilot programmes and innovation and ensure we have processes in place to identify and share learnings from best practiceWe will continue to partner with Health Innovation Manchester to keep Greater Manchester at the forefront of early cancer diagnosis and care. The partnership between Greater Manchester and Health Innovation Manchester grants the Alliance more streamlined access to new tools and diagnostics, enhances data collection / analytics capabilities through combined data and tech expertise and drives forward advancements in cancer diagnosis through increased research and funding. We will actively engage in nationally developed pilot programmes and promote participation in research studies for local patients, ensuring that we remain at the forefront of cancer research and innovation. We will also continue to collect and reflect on feedback across pathways and localities to further build a culture of quality improvement and self-reflection. We will look beyond Greater Manchester at innovation projects between other Cancer Alliances and Academic Health Science Networks.  Key actions for us will be:   * Review the findings and learnings from the current tranche of innovation projects and roll them out more widely as appropriate. * Stay at the cutting edge of innovation by learning from innovation outside of Manchester and piloting or adopting these where appropriate. * Cancer Alliance to continue to work with Health Innovation Manchester to foster the environment and networks to accelerate innovation with a specific focus on early diagnosis. * Cement Manchester as the leading place for innovation in cancer early diagnosis by supporting internal innovation, being willing to participate in pilot programmes and encourage participation in national research studies/clinical trials * Continue to gather, reflect and act on feedback and new ideas to further build a culture of self-reflection and quality improvement.   Only by identifying and harnessing innovation will we make the steps we need to towards the 75% early stage diagnosis ambition. With the collaboration and clinical expertise in Greater Manchester and within the Cancer Alliance we are in a strong position to move forward successfully in this field. We have a strong network of patient and carer representatives who can support and advise us through this work too and we will ensure this is a standing item for our early diagnosis plans going forward. |   C. Planned interventions  Please use the below table to set out the programme of activity your Alliance will deliver locally in 25/26 to improve rates of early diagnosis. Plans must be of sufficient scale to have a measurable impact on rates of early diagnosis. Interventions should support improvements in earlier diagnosis in 25/26, with a focus on symptomatic populations and more deprived areas/communities. Plans should draw on a combination of strategy pillars as described in the Cancer Alliance Planning Support Pack (timely presentation, primary care, screening uptake and innovation), as best befits the priority. ​ Insert rows as required. Please see the example in the first row to guide the level of information required. Plans do not need to include NHS-wide interventions covered elsewhere in the pack.  **Alliances can populate their table of planned interventions within the Part 2 template if preferred instead of this word document. There is no need to include the table of interventions in both part 1 and 2 templates.**   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Priority Addressed**  *(as outlined in section B***)** | **Strategy pillar(s)** | **Short project title** | **Target geography and population or cohort(s) including health inequality focus** | **Description of project** | **Evaluation and expected impact** | **Project milestones, including go-live date** | **Project budget (£)** | | *EXAMPLE:*  *Lung cancer* | *EXAMPLE:*  *Primary care, Innovation, Timely presentation* | *EXAMPLE:*  *Lung cancer referral, diagnostics and awareness improvement project* | *EXAMPLE:*  *Geography: X ICB*  *Cohorts include: Lung Cancer Screening non-responders (associated with those in most deprived areas); Lung Cancer Screening invitees who do not meet risk threshold for CT scan; symptomatic non-smokers*  *Health inequalities focus: Project rollout will start in the 25% most deprived PCNs with additional support provided by Primary Care Facilitators to deliver the interventions in these PCNs.* | *EXAMPLE:*  *Interventions planned to support improvements to referrals, access to diagnostics and symptom awareness for target cohorts include:*  *1. GP education focused on lung cancer in non-smokers and use of chest x-ray, developed in conjunction with GatewayC*  *2. CPD event to share learning from referral audits and learning event analyses*  *3. EMIS searches to identify Lung Cancer Screening non-responders/those ineligible for screening CT and prompt practices to review symptoms on next presentation*  *4. Roll out of GP Direct Access CT for higher risk cohorts across all PCNs in the ICB*  *5. Implementation of self-referral chest x-ray pathways for low- but not no-risk symptomatic cohorts*  *6. Public awareness campaign (C2DE 50+), including awareness raising for self-referral pilot and use of HUHY campaign resources on social media and with VCSE audiences* | *EXAMPLE:*  *Overarching measures:*  *- Proportion of emergency presentations (expected impact: 1% reduction) and referral rates (impact may vary dependent on self-referral uptake)*  *- Additional early lung diagnoses (expected impact: 40 additional lung early diagnoses)*  *Intervention evaluation:*  *-Increase in GP-requested chest x-ray (Diagnostics Imaging Dataset)*  *-Number of screening non-responders identified and followed up*  *-Use of self-referral service and number of patients diagnosed with lung cancer following self-referral chest x-ray (including assessment of health inequalities impact and reach)*  *-Improved access to GPDA chest CT from 60% of practices to 100% by the end of 2025/26*  *-Engagement and reach of targeted campaign activity* | *EXAMPLE:*  *April 2025 - Go live*  *May 2025 - GP education event*  *June 2025 - CXR self-referral pathway agreed*  *July 2025 - EMIS searches conducted*  *September 2025 - CPD event*  *October 2025 - GPDA chest CT live in 80% practices*  *October 2025 - CXR self-referral pathway live with targeted campaign activity*  *February 2026 - GPDA chest CT live in 100% practices* | *£X* | | **Priority Addressed**  *(as outlined in section B***)** | **Strategy pillar(s)** | **Short project title** | **Target geography and population or cohort(s) including health inequality focus** | **Description of project** | **Evaluation and expected impact** | **Project milestones, including go-live date** | **Project budget (£)** | | Symptom Awareness | Drive earlier presentation | Community outreach and engagement | Data led routes, including local insight and intelligence, to target geography and patient group where there is evidence of late stage presentation | Locality and VCFSE - Each locality to be awarded funding based on population size to support identification of and engagement with target populations within their locality and to work with locality organisation to identify the best organisation to deliver the messages.  - Tumour specific messaging (level 1)  - Primary Care is open  - General S&S awareness & mythbusting  - Community Outreach Projects (GM led) | Increased engagement in symptom recognition and patient empowerment  Increased early presentation | Locality proposal Q1; delivery Q2-4 | 250,000 | | Symptom Awareness | Drive earlier presentation | Community outreach and engagement | People of working age and in areas of high late stage diagnosis via Organisations who are involved in delivering cancer messaging as part of our community outreach and engagement programme. | Cancer Research UK engagement  CRUK Talk Cancer:  online Talk Cancer Workshops and Train the presenter workshops CRUK Cancer Awareness in the Workplace session will be delivered to workplaces identified through GM data and local insights. There will be 1 session delivered per locality. | Increase confidence of our VCSE sector to have cancer conversations.  Assurance for the Alliance that the correct messages are being given. | Online session to be deliver every quarter. F2F train the presenter to be delivered around launch of large campaigns.  Identification of workplaces Q1; delivery Q2-4 | 17,750 | | Symptom Awareness | Drive earlier presentation | Community outreach and engagement | Data led routes to target geography and patient group where there is evidence of late stage presentation | Mobile Community Outreach  Annual programme of mobile community outreach programmes based on learning from This Van Can projects delivered in 2023-4 and 2024-5, with locations in the areas with highest incidence of late stage diagnosis; focus on level 1 pathways; generic 'symptomatic presentation' messaging | Increased engagement in symptom recognition and patient empowerment | Continuation of existing projects M1; go live new projects M2 and continuation throughout 2025-6. | 125,781 | | Symptom Awareness | Drive earlier presentation | Community outreach and engagement | Data led routes to target geography and patient group where there is evidence of late stage presentation | Public and Patient Facing Communications: Asset development and promotion.All campaigns will have costs for design and asset production or revision; out of home advertising; community outreach and engagement programme.   * Primary care is open * General signs and symptoms and mythbusting. | Increased engagement in symptom recognition and patient empowerment  Increased early presentation | Go live April 2025 with ongoing active ‘always on’ programme throughout 2025-6 | 56,000 | | Reduce variation | Develop targeted interventions | Pathway Specific public & patient messaging | Priority pathways and locality variation as illustrated by RCRD and described above | Public and Patient Facing Communications: Asset development and promotion. All campaigns will have costs for design and asset production or revision; out of home advertising; community outreach and engagement programme. Assets to be used to support the mobile community outreach programme described above. | Increased engagement in symptom recognition and patient empowerment.  Increased early presentation.  Reduction in locality and pathway variation. | Go live April 2025 with ongoing active ‘always on’ programme throughout 2025-6 | 160,000 | | Reduce variation | Develop targeted interventions | Early Diagnosis Clinical Leadership | n/a | To provide dedicated clinical leadership and expertise to the early diagnosis elements of work with the pathway boards | Clinical leadership and expertise in the design and delivery of the ED projects to ensure accuracy of message and wider clinical engagement. | Go live April 2025-6 with 1PA per week per pathway | 110,920 | | Reduce variation | Develop targeted interventions: Lung | SRCXR Expansion | Individuals with concerning symptoms that may indicate lung cancer who experience barriers to access. Barriers include, lack of awareness or validation of symptoms, difficulty in getting an appointment and smoking stigma. | SRCXR Expansion  4 additional localities in GM (Salford, Manchester, Oldham, Trafford) to cover the remaining NCA footprint whilst also looking to cover patients whose provider is MFT | Reduction in barriers to access, particularly for targeted groups such as smokers and more deprived individuals. Reduction in GP appointments. Capturing some cancers at an earlier stage. | Achieving SOP sign off and backing from various boards.  GP/Locality backing.  Getting technical solutions in EMIS agreed  Oldham Roll out first, followed by MFT and NCA. Key clinicians identified.  Aim to have all 4 additional localities live in year before targeting remaining areas.  Evaluated through patient feedback surveys, numbers through the service, conversion rates and SoMe reach | 5,000 | | Reduce variation | Develop targeted interventions: Lung | LungAware | Individuals with concerning symtpoms that may indicate lung cancer who experience barriers to access. Barriers include, lack of awareness or validation of symptoms, difficulty in getting an appointment and smoking stigma. | LungAware  Stage 2 plan - 3 additional languages, integrated survey, new videos, and increased accessibility  Continued promotion | Increased engagement in symptom recognition and patient empowerment | Contract extension signed  Langauge translations to be integrated and additions to website expected by April  Promotion throughout the year.  New SRCXR localities to be added as and when live.  Evaluated through integrated survey, MSD data dashboard and SoMe reach | 10,000 | | Reduce variation | Develop targeted interventions: OG | Barratt’s Oesophagus | Targets patients at high risk of developing Barrett's Oesophagus. | Barrett's Oesophagus Programme  project evaluation following the conclusion of the case-finding project delivered in 24/25.  audit toolkit - primary and secondary care. Produce recommendations for use of capsule sponge in a community setting.  Audit toolkit - all patients with Barrett's Oesophagus should be enrolled in surveillance pathway. Surveillance pathway is embedded in all Trusts and patients are tracked appropriately | Identify patients for Barrett's surveillance to improve oesophageal cancer early diagnosis. | Evaluation - aim to complete by September 2025.  Audit toolkit – develop toolkit in Q1. Audits begin in Q2. Findings assessed and improvements put in place in Q3. | 5,000 | | Reduce Variation | Develop targeted interventions | Gynae | Two localities of Greater Mancester where there is evidence of late stage presentation. | Self-referral for PMB  To scope and implement a self referral system for post menopausal bleeding. NCA will be the secondary care provider. Development costs most likely required for the development of a self-access portal to support patient access.. | Increase patient awareness of signs and symptoms of cancer, empower patients to take charge of their own health. Support primary care by reducing the amount of GP appointments with patients able to refer themselves directly. | Plan to launch pilot in Q1, project milestones will be evaluating how many patients self-refer into the pathway. We will also monitor data on how many patients are diagnosed, and how many days this saved in the patients overall pathway. | 20,000 | | Collaborate with primary care | Streamline referrals / maximising the reach of primary care | Primary Care Education | General Practice (all staff), dentistry, pharmacy, optometry | The education of our primary care workforce is an essential part of the achievement of the nationally and locally set ambitions for early diagnosis. As part of our offer, we have a plan to include: annual one-off full day Early Cancer Diagnosis event; 6 cancer type specific face to face events ; 12 topic specific webinars with post-event assets to share with non-attenders; and, 2 specific events for both dental and pharmacy colleagues to supplement the wider offer. | Improved clinical knowledge and decision making; enhanced patients outcomes, safety and quality of care; increased efficiency and streamlined workflows; better team collaboration and multidisciplinary working; and, continuous professional development and innovation... | Programme to commence Q1 and continue at regular intervals throughout the remainder of 25/26 | 76,000 | | Collaborate with primary care | Streamline referrals / maximising the reach of primary care | Quality Improvement resource | General Practice | Continue our work with The Data Quality Team on the development of resources including the Clinical Decision Support tool - 'Think Cancer' to support general practice to improve the identification patients for a suspected cancer referral, referral quality and safety netting. | Continued development of the 'Think Cancer' tool and the accompanying resources will: enhanced diagnostic accuracy and early detection; improve patient safety and reduce errors; increased efficiency; enhanced adherence to clinical guidelines; and, reduce costs and resource utilisation. | Ongoing development and refinements to Think Cancer, loading of annual refreshed referral templated Q4. | 25,000 | | Collaborate with primary care | Streamline referrals / maximising the reach of primary care | PCN Cancer Leads | General Practice / PCNs | Each PCN will continue to have a designated Cancer Lead who are expected to act as the link to the Cancer Alliance and engage and disseminate resources, encourage update of education and training, and to submit an annual early diagnosis action plan which is reviewed by the Facilitators on an ongoing basis.. | Continue to improve early cancer detection by engaging with our offer and providing support to their PCNs and member practices. | Action plans to be returned by end Q1 and reviewed by Facilitators on quarterly basis. RAG rating applied to plans and engagement and reported to Early Diagnosis Programme Board | 325,000 | | Collaborate with primary care | Streamline referrals / maximising the reach of primary care | Primary Care Leadership | Primary Care | To ensure that the work we undertake has the appropriate focus and to maximise engagement for primary care colleagues we will be working with representatives from primary care including GPs, a Practice Nurse and a Practice Manager to promote our offer to all staff and to provide clinical and non clinical insights back to the Cancer Alliance to help develop our offer do that it is appropriate and valued by recipients across the whole workforce. | These roles will aid in the continued development of our engagement efforts across the workforce and the feedback provided will help shape our offer thereby further strengthening engagement. | Q1 all support roles to have a work programme reviewed on a regular basis and also reviewed by working group and reporting to Early Diagnosis Programme Board quarterly | 42,480 | | Collaborate with primary care | Streamline referrals | Gynae  Head & Neck | Primary & Seconday Care interface events | Audit of referrals between primary and secondary care. Primary & Seconday Care interface events, facilitated by the cancer alliance or other suitable party and held in-person. Head & Neck and Gynae. | Increased engagement from primary and secondary care. Key relationships sustained and improved to enhance patient care and early diagnosis for the future. Streamline referrals and ensure GM are referring in the same way. | Q2 | 4,000 | | Cancer Screening and NHS Wide Programmes | Improve screening |  |  | Breast, Bowel, Cervical screening and HPV: identify areas where uptake is low and design interventions to improve access and uptake – jointly with Section 7a team – additional detail to be included in next iteration of the plan | Any public and patient facing cancer screening communications activities will be delivered by the Cancer Alliance but funded by the Section 7a team. The resource required will be a human resource - the time of our comms & engagement team - rather than additional funding. | Q1 and ongoing | 0 | | Innovation | Harness Innovation |  |  |  | The Cancer Alliance ED team will continue to be involved in the national SBRI process to identify projects which the Cancer Alliance could be involved in. The Cancer Alliance will also work with Health Innovation Manchester and bring any proposals for funding in year rather than having a pot of funding to use for this as projects arise or are identified. Cost neutral to Cancer Alliance at this stage and will submit proposals for funding in-year as projects are developed/identified. |  | 0 |   **D. Staging completeness**   |  |  | | --- | --- | | **Q3 staging completeness rate** *(Q3 (July - September) 2024 staging completeness rate for your Cancer Alliance can be found from the* [*public staging dashboard*](https://digital.nhs.uk/ndrs/data/data-outputs/staging-completeness-dashboard)*.)* | **Actions to increase staging completeness in 25/26** *(Alliances with an overall staging completeness below 80% should use this space to set out actions that will be undertaken with their providers to increase staging completeness in 25/26. This should consider tumour sites (such as sarcoma and haematology) and providers where staging completeness is lower locally. You may also want to consider opportunities to improve data quality in other fields (such as performance status).* | | **GM staging completeness for Q3 2024 is 75.5% however there is variation across the 7 NHS Trust providers from 32.9% (Manchester NHS Foundation Trust (MFT)) to 90.8% (Wrightington Wigan & Leigh NHS Foundation Trust).**  **Three of the NHS Trusts in GM are above the 80% completeness level, 3 are between 60-80% and one below 60% (MFT).** | We have 4 NHS Trusts in GM who are below the 80% threshold, one considerably so which will be responsible for bringing the overall completeness in GM to below 80%. Excluding the MFT data would give a GM position of 82%.  The Cancer Alliance are aware of this issue with MFT data and understand this is due to the introduction of the EPIC system in September 2022.  The impact on the GM position is considerable given a significant amount of GM wide activity is delivered through MFT – e.g. bowel screening, breast screening, targeted lung health checks.  Working with the NHS GM contracting team to include this requirement in the 2025-6 contract for the 7 NHS Trusts in GM.  We will task the following Pathway Boards with responsibility for working across all Trusts to demonstrate improvement in staging completeness by the end of Q2 2025-6. These are the pathways where the data shows us that current performance at a tumour site level is <80%:  HPB; Head & Neck; Breast; Urological; Lymphoma; CLL; Bone & soft tissue; Endocrine; Myeloma | | | | | | | | |
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## 4 Workstream: Treatment and Care

### 4.1 Treatment Variation

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| **Deliverables:**   * Implement national priority recommendations from clinical audit/GIRFT reports to reduce variation in treatment in trusts not meeting the NHS-wide target:   + **Lung**: 70% of patients with NSCLC stage IIIB-IVB and PS 0-1 receiving systemic anti-cancer therapy (SACT).   + **Bowel**: 50% of stage III colon cancer patients receiving adjuvant chemotherapy following major resection.   + **Primary Breast**: 25% of primary breast cancer patients receiving immediate reconstruction following a mastectomy   + **Ovarian**: 80% of women with stage 2 to 4, or unstaged ovarian cancer receiving treatment (any type)   + **Pancreatic**: 65% of patients with non-metastatic pancreatic cancer (stages 1-3) and 35% of patients with metastatic (stage 4) pancreatic cancer receiving disease targeted treatment   + **OG**: Reduce the number of patients with OG cancer waiting more than 62 days from referral to first disease-targeted treatment.   + **Non-Hodgkin Lymphoma**: Reduce the number of patients with high-grade NHL waiting more than 62 days from referral to starting chemotherapy. * Continue to evaluate demand and capacity of SACT services where required - continue to evaluate the demand and capacity of SACT services across the Alliance footprint and feed into commissioning discussions. |

**Name and email of Cancer Alliance Lead Contact**: Lisa Galligan-Dawson. [Lisa.galligan-dawson@nhs.net](mailto:Lisa.galligan-dawson@nhs.net) and Sarah Hulme. Sarah.hulme1@nhs.net

**Narrative plans for 25/26**   
*Please explain how the Alliance intends to implement the priority recommendations in the identified providers and the resource required to deliver this programme of work, including strong clinical leadership. Plans can include; project approaches, analytical support, how the Alliance will engage with providers to discuss variation and possible improvements, any direct support to be offered to providers, and how engagement will be sustained across the year. Plans are only against recommendations where* ***trusts are not meeting the NHS-wide target***

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| Lung | NCA, Stockport, Tameside and WWL are all below the thresholds based on the latest data from 2023. System work will continue on pre-hab, re-hab for this cohort of patients to improve fitness to help patients through to treatment. This is the primary intervention, with continued investment and analysis to see the impact in the new data. |
| Bowel | NBOCA audit, shows Gm as a whole at 54%. Clinical pathway board feels this is a well supported pathway in GM. Further audit work will be completed In Q1-Q2 25/26 to further review variation, including factors of health inequalities. |
| Primary Breast | Latest data (2023) shows GM at 35% (system level NApPRi dashboard). Local data will help deep dive into variation and action |
| Ovarian | Latest data from Q3 2022 was 78% at system level. Actions include working alongside the PWB to develop local, real time audit to understand the reasons for patients not being offered treatment, and then agreeing actions which will be monitored to drive improvement |
| Pancreatic | Latest date from Q2 2023 was 44%, 23% respectively at system level. Whilst there are questions about the robustness of data, action will commence with local systemwide audit including health inequalities to understand not only the most recent data, but the underpinning factors which may be determinants. Other actions which have already commenced is scoping for CTOC (the cancer alliances cancer treatment and optimisation clinic), following the successes seen in lung with increases in curative intent treatment rates, patient optimisation and reduced wait times |
| OG | Latest data, 23 suggests 24% at system level. Local data suggests this is now close to 50%. Work continues from last year, diagnostic bundling, MDT re-design, CTOC roll out – go live scheduled for May 25. |
| Non-Hodgkin Lymphoma | Latest system data 77%. This is 14% above national average. Local work will take place to understand variation and action to address |
| SACT | Work continues from 24/25 to understand SACT C&D across the GM footprint. Main christie site data complete, with greater analytics support coming on line in May to further develop this work. |

*How you plan to address Health Inequalities as part of this work (optional)*

A GM audit portal is being established, which will allow all local audit to be assessed through a range of lenses including IMD, ethnicity, age, MDT attended to understand variation and address inequalities that would not otherwise be visible.

### 4.2 Living With and Beyond Cancer (LWBC)

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| **Deliverables:**   * Complete the embedding of local accountability arrangements ('local agreements') for personalised care interventions and Personalised Stratified Follow Up (PSFU) pathways, including capabilities in digital tracking of PSFU patients and monitoring the sustained delivery of PSFU and personalised care benefits. * Deliver co-produced improvement plans and agreements for sustainable commissioning and delivery, demonstrating community/system collaboration, for:   (a) psychosocial support - continued delivery of pre-existing plans;  (b) cancer prehabilitation (per NIHR/Macmillan guidance) - complete plan and begin delivery;  (c) behaviour change and other intervention(s) across the cancer pathway that support increasing any form of physical activity - begin delivery. |

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

**PSFU and Personalised Care**  
  
**Narrative plan for 25/26**   
*Please describe how agreements for local accountability on sustaining PSFU and personalised care will be completely embedded, including capabilities in digital tracking of PSFU patients, and referencing personalised care and PSFU data as appropriate.*

Personalised care – (fully establish personalised care interventions) - All Trusts apart from The Christie are submitting personalised care data to COSD. MFT historic data has not uploaded and there are some sporadic issues with COSD uploads due to HIVE/EPIC integration which is being monitored and escalated separately given impact on multiple performance requirements (not just limited to personalised care). The Christie plan to incorporate the HNA data into the COSD rebuild which is currently being carried out to meet the v10 specification. The Christie have submitted some test data to the system and are working with COSD to finalise.

The Alliance will continue to monitor the GM Personalised Care Key Performance Indicators (KPI) that includes quarterly thresholds to support performance monitoring across GM and maximise data completeness and quality using the Alliance performance dashboard built on curator.

In 25/26 a full personalised care service specification will be added as a contract variation into the performance contracts between the ICB and Trusts. This will support delivery of the following in planning guidance:

· Complete the embedding of local accountability arrangements ‘local agreements’ for personalised care interventions and Personalised Stratified Follow Up (PSFU) pathways, in line with NHS-wide guidance, within local commissioning and/or provider monitoring arrangements’.

In 25/26 the Alliance Personalised Care Team will work with Clinical Pathway Boards to audit the use of tumour specific treatment summary templates and understand barriers to completing end of treatment summaries in order to increase their uptake. We will also work with primary care to ensure that treatment summaries are visible to GP’s once they have been received by a practice.

We will continue improvement work with Clinical Pathway Boards to review and update Treatment Summary letter templates to optimise clinical and patient information (signs & symptoms, HWB support etc). Approved letter templates will be shared with Trusts to upload onto document management systems and also uploaded onto Infoflex for PSFU pathways to ensure equity of care across the Alliance footprint.

PSFU pathways and protocols have been developed and approved for 4 key pathways and built on the digital remote monitoring system (Infoflex) during 2024/25. All Trusts except The Christie are now connected to the dRMS with plans being developed for the Christie to connect during Q1 25/26. The Alliance are funding the licencing and cloud hosting costs for Infoflex on behalf of GM for an additional year from April 2025 to the end of March 2026 when a full re-procurement process will be completed for a digital remote monitoring system that supports delivery of PSFU and SQD in GM. The Alliance will not fund the dRMS for PSFU beyond April 2026 but will utilise the time to create plans with individual Trusts to help them ensure that all pathways are embedded and sustainable by the end of the financial year 25/26. We will work with Trusts to co-produce plans to highlight where they need additional resource and support to fully implement pathways. Once these have been finalised we will move forward with them from Q1/2 onwards.

GM have developed a PSFU service specification and data reporting requirements. In 25/26 we will report metrics directly from the dRMS into a GM wide dashboard to enable oversight for all Trusts and GM as to the current position of PSFU to ensure pathways are fully embedded.

GM funded system manager post extended for 12 months until the end of March 2026 to continue to support individual teams in their training needs both in direct relation to using the dRMS and help with more general questions about PSFU.

To support standardisation, the high-quality delivery of the PSFU and provide evidence that a dRMS is the only safe way to track patients, in Q3 24/25 the Alliance undertook an evaluation of PSFU which has provided feedback on education needs of all staff involved in the pathway which the Alliance will be supporting through 25/26.

**Psychosocial**

**Narrative plan for 25/26**   
*Please outline the continued delivery of the Alliance's co-produced improvement plan for psychosocial support. NB Detail is only required where the plan has changed from the 2024/25 plan.*

Utilising joint Alliance and GMMH funding we will deliver year 2 of a 2-year project in 25/26. We will continue to collaborate with The Christie Hospital NHS FT Psycho-Oncology Department, GM Cancer Psychology & Mental Health Delivery Group, Practitioner Psychologists working into other GM-hospital cancer services to deliver on the ambition of demonstrating a Greater Manchester-wide ‘whole system approach’ to improving access to psychological therapies and emotional care for people affected by cancer. The creation of this GM-wide ‘Psycho-Oncology Hub’ will also aim to provide training, consultation and supervision to cancer keyworker staff (e.g. Clinician Nurse Specialists) in delivering to Levels 1 and 2 of the NICE (2004) guidelines. There will be an expectation that hub staff take part in designing, developing and delivering training across Greater Manchester. The following key milestones will be the focus for Year 2:

• Onboard the Clinical Practitioners into the GMMH LTC service and the Alliance project.

• Work in partnership with Greater Manchester Mental Health NHS FT (GMMH), to improve how people affected by cancer (PABC) can gain access to high quality and evidence-based community psychological therapies across the GMMH footprint (Bolton, Salford, Trafford, Wigan, Manchester).

• Finalise the referral and self-referral pathways into a step 3+ therapy provision within GMMH Psychological Therapy Service, a Talking Therapies for Anxiety and Depression (TTad) reporting service.

• Provide highly specialist psychological assessment for PABC with complex, co-morbid, chronic common mental health problems as well as ensuring the appropriate provision of high-quality, individual and group therapy.

• Co-develop a performance and clinical quality dashboard to monitor the service and demonstrate where value has been added and identify areas for work, engagement or where additional awareness and support may be indicated at speciality level.

• Contribute to the Psych Level 2 education face to face module pan Greater Manchester and create a mechanism with the GM Cancer Academy to connect CNS Level 2 trained practitioners to appropriate supervision/supervisors in accordance with guidance.

• Utilise data collected from the GM-wide supervision contact platform to identify any shortfall in supervisors across the GM footprint and influence at a national level to provide a solution.

• Undertake appropriate audit, research, and service development activities pertinent to the evaluation and development of the service. This will help ensure service continuity and scale up and spread to the remaining Greater Manchester localities (dependant on engagement from Pennine Care NHS FT who cover the remaining localities (Bury, Rochdale, Oldham, Tameside).

• Co-produce patient resources around sex, relationships and intimacy, with development of GM Cancer Academy CNS modules to complement this and enable the workforce to respond to increased awareness and engagement with this aspect of holistic care.

**Prehabilitation**

**Narrative plan for 25/26**

*Please outline the delivery of the Alliance's co-produced improvement plan for prehabilitation (per Macmillan/NIHR guidance).*

The Alliance will look at what changes can be implemented to ensure that targeted help is offered to those patients who will benefit most by utilising a screening/triaging system for pre and during treatment (prehab) and post-treatment (rehab and recovery). The aim would be for universal provision of needs based prehabilitation. We will do this by:

· Creating a targeted prehabilitation triaging system for all patients diagnosed with cancer working with existing P4C team, commissioning, personalised care leads, clinical pathway boards, patient and carer voices and other relevant stakeholders.

· Creating advice and guidance support for patients and professionals to support these changes.

· Creating associated educational material for signposting in collaboration with colleagues in early diagnosis and primary care, workforce and education, clinical teams and patient and public voices team and communicate this by working with the comms & engagement team

**Physical Activity**

**Narrative plan for 25/26**

*Please outline the delivery of the Alliance's co-produced improvement plan for the offer of brief behaviour change and other intervention(s) across the cancer pathway that supports increasing any form of physical activity.*

The Alliance will co-produce a “Live Well with Cancer Pathway” for patients in GM which will incorporate the prehabilitation offer, as well as awareness and access to what other services are available to patients throughout their entire pathway from diagnosis to living with and beyond cancer that can support them with health and wellbeing beyond and as a consequence of their cancer diagnosis and treatment. We will do this by:

Pre-diagnosis:

· Co-producing a system for all patients on a SCR pathway to be signposted to a VBA package including the importance of physical activity, diet and nutrition and smoking cessation.

· We will do this by working with previous stakeholders of Live Well with Cancer phase 1 and colleagues in early diagnosis and primary care, workforce and education, clinical teams and patient and public voices team. This will ensure we utilise existing resources and understand and address any existing gaps where financially possible.

Post treatment:

· Creating an offer that can be supported by wider GM Active community-based colleagues in local community leisure centres and other physical activity offers.

o Upskill existing staff

o Create a communication package for both professionals and PAbC

o Utilise an access for all approach by working with providers of existing PARS schemes or rehab sessions so patients with multiple comorbidities can engage in recovery and rehabilitation together and working with VCSFE colleagues providing non-gym based physical activity offers.

· Creating a digital/online offer

o Utilising existing resources from a central hub to sign post to other online and community resources

o Creating education and communications packages in collaboration with WF&E and comms to ensure system wide knowledge

o Delivering education via face to face and online sessions

· Utilising the Live Well with Cancer Locality reports to sign post to face to face support close to home

o Engaging and educating stakeholders to ensure they are sharing and promoting the LWWC locality reports as a standard resource

*How you plan to address Health Inequalities as part of this work (optional)*

For the LWWC phase 1 work we have engaged heavily with 10GM and also local community groups who have specialist knowledge of some of the seldom heard from communities. We will utilise this stakeholder knowledge at each stage of the creation of any change.

The psychological support project may create health inequalities as GMMH does not cover the GM footprint. This will serve as a proof of concept to Pennine Mental Health services to then utilise the successes of the project in a bid to fund a similar service. PPIE and community groups will be consulted on the project EIA and the animation series.

Until a digital solution is launched for Genomic testing across GM, inequality data will be difficult to measure. This work will be built into future audit activity when measures are available. Any educational material and awareness materials created will have AD tags, subtitles and translation into main languages will be considered. Stakeholder groups will be consulted in the production stage.

## 5 Workstream: Cross-cutting

### 5.1 ACCEND: Supporting patient care, performance and productivity through enabling recruitment, retention and upskilling in key roles

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| **Deliverable:**  Facilitate the implementation of the ACCEND Career Pathway, Core Cancer Capabilities and Education Framework in providers for relevant nursing, AHP and support worker roles in cancer |

**Name and email of Cancer Alliance Lead Contact**: Suzanne Lilley, Suzanne.lilley2@nhs.net

**Narrative plan for 25/26**   
*Please outline how the Alliance will implement different aspects of ACCEND (e.g. training opportunities, uniform job descriptions, etc) across each of the levels of practice within the ACCEND framework, noting where activity will be cross-cutting / overarching, including expected completion, and interdependencies both locally and nationally.*

The Greater Manchester Cancer Alliance is part of the National ACCEND steering group and has therefore made significant progress with implementing ACCEND through taking a strategic approach from the outset. In 24/25 the approach evolved from raising awareness of ACCEND to identifying and supporting early adopters / champions. The focus for 25/26 will be to start transitioning ACCEND to BAU for the specialist workforce. This will be achieved through the following activity:

Strategic levers

* Strengthening relationships with Chief nurses / Chief Allied Health Professionals. All providers have developed an initial action plan to support embedding ACCEND including building into existing governance processes. Biannual workshops will be held with CNs and CAHPs to support ACCEND to move to BAU for the specialist workforce
* Matrons are a key stakeholder group for ensuring ACCEND becomes BAU in appraisals, supervision etc. – further resources / engagement sessions will be developed to support matrons with this work (Q4).

The following section includes specific activity for the different levels of practice:

Supportive:

* Standardised job descriptions will continue – a Cancer Care Coordinator JD was standardised in 24/25 and so the focus for 25/26 will be navigator and MDT Coordinator JDs (Q4)
* A standardised training package will be developed specifically for support workers called LEAP (Learn, Empower, Advocate, Provide). This aligns to the national PCCP however, because numbers are limited on the PCCP course due to this being a national offer, LEAP will help to reduce inquity in access to education for GM support workers (Q1)
* A GM CSW event will take place to launch LEAP and discuss how to use ACCEND through the ePortfolio (Q1).

Pre-reg wf:

* Building on previous pilot projects (nurses and AHPs) the workforce and education team will work with Lead Cancer Nurses (LCNs) to expand cancer learning environments across GM providers (Q4)
* Continue to work with Higher Education Institutions to influence cancer content in pre-registration curricula and build cancer specific additional educational offers aligned to ACCEND capabilities (Q4)
* Embed ePortfolio taster sessions into the pre-registration curriculum, ensuring third-year students build an evidence log to support entry-role applications (Q2).

Registered wf:

* Building on previous pilots to attract registered nurses / AHPs into cancer e.g. *Aspiring CNS programme and Internation nurses aspiring pilot,* the team will work with LCNs to expand aspirant cancer programmes to the registered workforce (Q4)
* Develop an education package for the registered workforce mapped to ACCEND capabilities to complement the aspiring programmes (Q2).

Enhanced to advanced:

* Every provider has identified ACCEND mentors (early adopters consisting of nurses, AHPs and support workers), the GM Community of practice will evolve into a dedicated forum to support mentors in this role and help with the wider rollout (Q1)
* A sample of mentors from each provider will be supported to achieve their coaching qualification to support them in this role (Q1).

Additional cross cutting activity:

* Tumour specific multi-professional induction / development packages will be developed in collaboration with Pathway boards for the following pathways:
  + Skin (Q1)
  + Lung (Q2)
  + Breast (Q2)
  + Haem (Q2)
  + Neuro (Q4)
  + HPB (Q3)
  + Head & Neck (Q3)
  + Colorectal (Q2)
  + upper GI (Q4)
  + AO (Q2)
  + Urology (Q4)
* 4 x Q&A webinars open to all levels of practice (one per quarter)
* Support an additional framework for therapeutic radiographers in collaboration with the Society of Radiographers (Q4)
* 12 month rolling communications campaign to promote ACCEND and simplify messaging
* Assess ePortfolio usage and education being logged to identify gaps and trends in workforce engagement with the ACCEND framework. This will help to inform our future approach and development of educational offers (Q3)
* In response to user feedback, develop the ePortfolio to build in additional functionality (team skill mix and appraisal function) to support professional development and career conversations (Q4).

*How you plan to address Health Inequalities as part of this work (optional)*

The alliance workforce and education team is working with all providers including those which serve more disadvantaged communities to support implementation of the ACCEND framework which will ultimately help to standardise practice and ensure all patients receive the same quality of care irrespective of where they live. Organisations in disadvantaged areas face greater challenges attracting and retaining staff and so to address this we will continue to standardise job descriptions and develop pathway specific standardised multiprofessional induction and development plans to ensure all staff receive equitable levels of support and a comprehensive development offer throughout their career trajectory. Additionally we will work with LCNs to ensure learning environments expand across all providers to attract the future workforce.

### 5.2 Experience of Care and People & Community Engagement

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| **Deliverables:**   * Use, and encourage Trusts/System partners to use, insight and feedback (including CPES/U16CPES) to understand how people are experiencing cancer services to inform improvements to services. * Maintain a comprehensive approach to community and public engagement, ensuring that the diverse voices of local communities are heard and integrated into all work programmes. |

**Name and email of Cancer Alliance Lead Contact**: [philippa.harper@nhs.net](mailto:philippa.harper@nhs.net) and [f.howle1@nhs.net](mailto:f.howle1@nhs.net)

**Narrative plan for 25/26**

*Please cover how the Experience and Engagement Impact Measurement Framework will be implemented. Include information on your approach to engagement, including details of any PPV forums and how representative and diverse engagement activity, through community outreach, will be undertaken with a focus on reducing health inequalities.*

*Please describe how the Alliance will work with Trusts/System partners to use insight and feedback (including CPES and U16's CPES) and to increase profile of the surveys, and how you will utilise the data to generate service improvements.*

The Personalised Care Team in the Alliance have co-developed with the GM Lead Cancer Nurses a set of personalised care specific experience of care questions to give us more insight into the delivery and quality of personalised care interventions.

The questions have been approved and shared with each Trust Personalised Care Lead to agree an internal process with their information governance teams to ensure the survey can be shared appropriately and data collected. Each Trust have agreed a different process e.g. use as a new survey or adding to existing service experience surveys, and that they would be happy to share their anonymised data with the Alliance. The Alliance Personalised Care Clinical lead will collate the data and insights and present at the Personalised Care Board in Q2 to identify gaps/common themes and develop an action plan to deliver in Q3 and Q4 to address any areas of low experience.

The Alliance worked with the Christie IG lead in Q4 of 24/25 to set up the process for sharing 2024 free text comments from the National Cancer Patient Experience Survey (NCPES) with Cancer Alliances when they are published in Summer 2025. We completed and shared the Data Sharing Agreement (DSA) as requested by NHS England Information Governance team which was required by each Cancer Alliance. Once the CPES free text is received in Q2 we will share with corresponding teams in the Alliance (e.g. Personalised Care, Early Diagnosis and Operational Performance & Faster Diagnosis) based on the questions to review and agree action plans in response if needed.

In relation to promoting the CPES/U16CPES surveys, we will continue to share them via our owned communications channels including social media and newsletters to targeted groups of people such as patient and carer representatives and workforce across Greater Manchester to support the rollout to their patients directly.

Community outreach and engagement is a key priority for the Greater Manchester Cancer Alliance and as such we will deliver a programme of community outreach and engagement work focused on the pathways and populations that we have identified as requiring specific interventions to make progress in relation to the early diagnosis of cancer by increasing people’s understanding and awareness of cancer symptoms.

This will be delivered in various ways including community events and working with the VCFSE sector to target the general public as well as specific communities in line with our Greater Manchester Early Cancer Diagnosis Strategy.

This work aligns with our priorities surrounding increasing public understanding of cancer and building symptom awareness as well as reducing variation. By educating individuals about the signs and symptoms of cancer, we empower them to seek timely medical advice, which can lead to earlier detection and better outcomes. We also recognise that variation needs to be identified and further understood to mitigate its harmful effects.

We will also use traditional methods of communication to raise awareness of this programme of work to involve more people, such as using social media and media outlets. This includes sharing individual person-centred content to engage with specific communities so they hear and see familiar or similar faces/voices to them. We will also ensure that we recognise health inequalities and roll out specific and diverse messaging as required.

*How you plan to address Health Inequalities as part of this work (optional)*

We will continue our work to reduce health inequalities across all programmes we undertake at the Greater Manchester Cancer Alliance to improve the experience of those living with cancer.

We will work together with communities and other organisations, including those within the voluntary sector, to understand the barriers as well as develop and deliver solutions to overcome them.

We will co-produce materials and campaigns with patients and communities from health inequality groups/Core20Plus populations, use data and insights to target campaigns with a particular focus on Core20Plus populations and other population that experience health inequalities in access experience or outcomes in cancer, and represent our communities and the target population in our comms and produce culturally competent comms.

In doing this, we will embed patients and communities across our work at the alliance, ensuring we hear from people who represent our communities including those who experience health inequalities.

### 5.3 Alliance Organisational Development

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| **Deliverable:**  Maximise the effectiveness of the Cancer Alliance as a local system partner by prioritising organisational development, informed by input from key stakeholders and guided by the pillars of the 'What Makes an Effective Cancer Alliance' report |

**Name and email of Cancer Alliance Lead Contact**: Alison Armstrong, alison.armstrong7@nhs.net

**Narrative plan for 25/26**   
*Please outline a brief assessment of capability, capacity and impact in relation to the core Alliance roles as described in the 'What Makes and Effective Cancer Alliance' report, with particular reference to the following:*

*• Key activities that will be completed in-year as part of OD plans created in 2024/25, including anticipated timescales;*

*• How the Alliance will monitor progress against OD priorities, and impact of activities;*

*• How the Alliance will either carry out stakeholder engagement in 2025/26, or take action based on stakeholder engagement carried out in 2024/25.*

• Insight – Data Responsibility for this work area sits within the Director of Performance portfolio, and GM Cancer Alliance demonstrates strong capability in utilizing data to drive decision-making and service improvement. It is recognized as a trusted authority on cancer data within the system, providing high-quality intelligence that informs both strategic and operational planning to the Alliance, the ICB and system provider partners. The Alliance effectively integrates local intelligence with quantitative data, ensuring a comprehensive understanding of challenges and opportunities. Governance structures are in place to monitor and address areas of need, and there is a clear commitment to using data insights to identify and reduce health inequalities.

The Alliance benefits from a team of dedicated subject matter expert analysts who support both reactive and proactive data analysis. Access to a centralized ICB level data repository, (which contains national commissioning datasets and local dataset initiatives such as the GM Cancer PTL and the GM Primary Care dataset), facilitates consistent reporting and enables system-wide visibility. Continued investment in professional development is necessary to ensure that analytical teams remain equipped with the latest methodologies and technological advancements.

The impact of data-driven approaches within the Cancer Alliance is evident in the improvements seen in service delivery and strategic planning. By leveraging data insights, the Alliance plays a key role in identifying gaps in care and informing targeted interventions. The use of evidence-based intelligence supports decision-making at local, regional, and national levels, ensuring efficient use of resources. Furthermore, the Alliance’s focus on addressing health inequalities through data is fostering a more equitable approach to cancer care.

• Insight: GM Cancer Alliance has a dedicated clinical outcomes data group and system road-map on using outcomes data to drive increases in survival, curative intent treatment and neo-adjuvant and adjuvant treatment pathways through the optimisation of patients. The GM CTOC programme – Cancer Treatment &Optimisation Clinic model has delivered significant improvements in lung cancer outcomes, and is being rolled out across other Tumour sites, linked with operational performance and treatment variation. GM Cancer Alliance has a programme of work targeted to metastatic disease and driving to improve survival and improved outcomes for all patient groups. Patient outcomes is a key focus and golden thread alongside inequalities running through all domains.

• Planning: The Cancer Alliance plays an active roll in system planning, working closely with the ICB, providers and other system groups to support the development and review their plans providing guidance and expertise.

• Delivery : The Cancer Alliance structure is well established and evidenced in the organogram. In 24/25, additional permanent posts were agreed in conjunction with the host provider (The Christie NHSFT) and we aim to consolidate contract arrangements for the remaining Cancer Alliance staff to ensure a sustained core function for the Alliance to maintain the capacity and capability to deliver. The biannual GM Cancer Alliance team engagement events are scheduled to maintain the positive culture and support employee engagement and experience. An action plan to respond to the annual staff survey will be developed in Q1 25/26 and improvements discussed and facilitated at these biannual events. The Alliance has a pro-active and well established, staff-led EDI working group which will draft a plan of 25/26 activities which are promoted at the monthly team meetings and ‘coffee and cake’ catch ups and the Senior Leadership Team meetings. The Alliance will monitor progress against OD priorities via the Senior Leadership Team weekly meeting and the monthly Programme Assurance Meetings.

• Financial Management: Formalised financial expertise is included in the MOU with GM Cancer Alliance host provider. The assurance processes will include a monthly finance position presented by each of the programme directors and a quarterly update given by finance colleagues. The Greater Manchester Cancer Alliance has identified a protected contingency/innovation fund to support mid-year flexibility for 25/26. Tracking of spend will thus be closely monitored and any slippage utilised by the identified ‘in year’ initiatives.

• Relationships: GM Cancer Alliance has strong working relationships across the GM system. Stakeholder engagement and collaboration will continue including via triannual Cancer Leads Forums, membership of the Pathway Boards, Programme Boards and Cancer Board. In November 2025 Greater Manchester Cancer Alliance will deliver a GM Cancer Conference will showcase the work of the Cancer Alliance and evidence the value of the Alliance to the Integrated Care system and our population. A series of locality visits will be held with all the 10 ‘places’ in Greater Manchester as a peer to peer conversation to support the identification of additional areas of improvement and joint working. From an Operational Performance and treatment Variation perspective, there is frequent attendance at GM Executive Medical Directors and GM Chief Operating Officers forum. The Cancer Alliance hosts fortnightly meetings with the GM cancer managers, monthly meetings with Trust improvement leads. The cancer alliance also provides expert advice to GM ICB relating to cancer performance and improvement. The Cancer Alliance is well integrated with provider Trusts and attends a range of improvement, oversight and service re-design forums.

• Approach to Assurance: The GM Cancer Alliance will retain its system governance processes, ensuring transparency in the identification, monitoring and response to deliverables within the given financial envelope and management of risk. The formal Cancer Alliance governance meetings will be held twice monthly and feed up into Cancer Board. All elements of the work programme will be incorporated into these structures and feed into the ICB.

• Innovation GM Cancer Alliance is well renowned for its innovative approach in all areas. Innovation is a key aspect of all domains, and is clearly evident in delivery and improvement plans. We will continue to be pro-active in the SBRI process and have identified some protected funding for in-year innovations in 25/26. The Cancer Alliance will aim to improve relationships with Health Innovation Manchester in 25/26 which will help identify opportunities, create new innovative ideas as a means to foster innovative practice. We are well connected with Manchester Academic Health Science Centre and can join forces to promote innovation.

*How you plan to address Health Inequalities as part of this work (optional)*

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## 6 Other Local Projects

(Optional) Please use this space if you would like to detail any local projects *(e.g. innovation, workforce)* where you will use your place-based service development funding to undertake work not already described in narrative plans:

Click or tap here to enter text.