

## Greater Manchester Cancer Board

### Minutes and Actions

**Meeting time and date: Monday 25<sup>th</sup> November 2024 14:00 – 16:00**

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

**Chair: Roger Spencer**

Members Present		
Name	Role	Organisation / Representation
Roger Spencer (RS)	Chair/Chief Executive	The Christie NHS Foundation
Susi Penney (SP)	Medical Director	GM Cancer Alliance
Ali Jones (AJ)	Director of Cancer Commissioning & Early Diagnosis	GM Cancer Alliance
Alison Armstrong (AA)	Associate Director	GM Cancer Alliance
Claire O'Rourke (COR)	Managing Director	GM Cancer Alliance
Lisa Galligan-Dawson (LGD)	Director of Performance	GM Cancer Alliance
Sarah Taylor (SaT)	Associate Medical Director	GM Cancer Alliance
Matt Evison (ME)	Associate Medical Director	GM Cancer Alliance
Thomas Thornber (TT)	Director of Strategy	GM Cancer Alliance/The Christie
Roger Prudham (RP)	Lead Cancer Clinician representative	NCA NHS Foundation Trust
Clare Garnsey (CG)	Associate Medical Director	GM Cancer Alliance
Dan Gordon	GM Elective Care Programme Representative	NHS GM
Nabila Farooq (NF)	Patient & Carer representative	GM Cancer Alliance
Suzanne Lilley (SL)	Workforce & Education Programme Director	GM Cancer Alliance
Freya Driver (FD)	Programme Director for Personalised Care	GM Cancer Alliance
Susan Crabb	Answer Cancer Programme Manager	Salford CVS
Dr Ashwin Ramachandra (AR)	Associate Medical Director	NHS GM – Tameside (representing GM locality AMDs)
Yvonne Summers	Medical Director Representative	The Christie NHS Foundation Trust
Hannah Stirzaker	Strategic Lead in Cancer and Inequalities	10GM
Andrea Edmondson	Quality Representative	NHS GM
Pippa Harper	Comms and Engagement Lead	GM Cancer Alliance



Brian Stott (BS)	Patient & Carer representative	GM Cancer Alliance
Rachel Hart (RH)	Genomics representative	NWGMSA
Karen Jewers	Lead Cancer Nurse	WWL
Susan Todd	Programme Director for Transformation	GM Cancer Alliance

Guests		
Name	Role	Organisation / Representation
Dan Clark (DC)	Project Manager	GM Cancer Alliance
Sophie Moore	Senior Team Administrator	GM Cancer Alliance
Sarah Carr	Senior Team Administrator	GM Cancer Alliance
Andrea Webber (AW)	Project Manager	GM Cancer Alliance
Chelliah Selvasekar (CS)	Colorectal Clinical Lead (Deputy)	GM Cancer Alliance
Sarah Hulme	Cancer Performance Delivery Officer	GM Cancer Alliance
Katie Law	Project Manager	GM Cancer Alliance

Apologies		
Name	Role	Organisation / Representation
Lisa Spencer	GM Trust Director of Strategy representative	NCA NHS Foundation Trust
Philippa Johnson	Co-Chair/ GM Place Lead Representative:	Philippa Johnson
Ed Dyson	NHS GM Integrated Care Board Representative	NHS GM
Neil Bayman	Medical Director Representative	The Christie NHS Foundation Trust
Leah Robins	GM Trust Chief Operating Officer representative	NCA NHS Foundation Trust
Julia Charnock	Specialised Commissioning Representative	NHS England and NHS Improvement
Victoria Dickens	Allied Health Professional representative	NCA NHS Foundation Trust
Rob Bellingham	Chief Officer for Commissioning and Population Health	NHS GM
Sally Parkinson	Director of Finance Representative	The Christie NHS Foundation Trust
Gareth Robinson	Chief Officer – System Improvement	NHS GM
Jennifer Gammack	Programme Director – Sustainable Services	NHS GM Integrated Care
Rae Wheatcroft	GM Trust Chief Operating Officer Representative	Bolton NHS Foundation Trust
Vicky Sharples	Chief Nurse Representative	The Christie NHS Foundation Trust



1. Welcome & Review of Meeting Summary and Action Log	
<b>Discussion Summary</b>	<p>RS noted a few apologies today, so deputies are present, COR not present today but is joining online.</p> <p>No notes on previous summary and action log, actions signed off except escalation of psychosocial to Pennine colleagues – PJ not present and the action is sat with her.</p> <p>RS mentioned dermatology update is not being presented at the Board despite being listed on the agenda, so we are not able to get assurance re the level of momentum from the programme. Need to make some escalation/representation from Cancer Board with concerns about the work not being done as fast as the system needs it to be. Will take expertise from the team on how these representations need to be made.</p>
<b>Decisions, actions, and responsibility</b>	Dermatology programme requiring escalation/representation from Cancer Board colleagues.

2. Update from RS on National Update / ICB / TPC/System Board Review	
<b>Discussion Summary</b>	<p>Vicky Sharrock (VS) to deliver the System Board Review update, Rob Bellingham not in attendance today to update from an NHS GM perspective.</p> <p>RS updated on the national position from a cancer point of view. Colleagues have been involved in national cancer programme activities – draw attention to the fact we have confirmation that in the forthcoming 10-year plan development, there will be a dedicated cancer section. A standalone dedicated cancer plan has been rested. There are a number of ways in which inputs to the 10-year plan will happen and how we can engage – organisational arrangements underway and work underway in NHSE infrastructure to input.</p> <p>There are specific cancer programme activities being undertaken to make sure there has been full consultation and engagement on specific and dedicated parts of the cancer 10-year plan. SP, COR attended a recent national Cancer Alliance meeting with the opportunity to engage with other cancer leadership ideas and dedicated national cancer board activities in next 2 months, dedicated to populating the 10-year plan cancer section.</p> <p>SP mentioned that Peter Johnson is keen to hear from alliances, and there is an inference that there will be opportunities for alliances to have a targeted meeting and information will be sent out about that – particularly important that the clinical voice is heard. They are changing how they are engaging with us, but they do have an engagement programme going into early next year. Alliances will be putting an alliance opinion forward in line with workstreams – emphasis on early diagnosis and prevention.</p>



TT queried around the Cancer Alliance role in this. SP responded that at this point in time, this is vague, they have online engagement happening, and also targeted sessions where we will host but we are awaiting news on these sessions– keen to engage but the how is missing at the present

RS updated on ICB/TPC – challenged in terms of operational and financial performance, the update on this is that as we progress through the financial year, the circumstances are more challenging even than in previous months, the consequence is around 2 things: every aspect of the ICS must examine what it can contribute to improve performance, and financially. The cancer programme and other system programmes are being asked to understand what contributions they can make. The good news from the cancer system is that the financial position as a programme is on plan. From a cancer board point of view, it gives context for planning for the next financial year. Indication of the high level of pressure – on month 7 the ICS is aiming to hit minus £175m but at the moment the outlook is at least another £75/80m – mainly sat in the ICB.

CG asked if anyone heard around the Amanda Pritchard keynote speech – does that mean anything for us? Felt as if things were moving away from the ICB in terms of performance. RS responded that we have a clear direction, things will change with oversight of activities in performance and finance. The substance of it is yet to be described.

The performance management aspect of our activities will come directly from NHSE, via the regional route with ICB colleagues asked to focus on something slightly different (development of community services, etc.).

RS then explained what we will do from a Cancer Board/programme point of view. We have a plan, the formal assurance process at NHSE level running where we work with the ICB on the same thing. RP mentioned from his perspective, those in tier 1 answer to NHSE.

VS updated on the System Board review: there are 8 programme boards/groups to review and determine their place/structure/contribution to the system. There has been some progress made in identifying improvements. In terms of the cancer programme, not much will change other than to make sure we are reporting correctly.

The 8 groups are in different stages of maturity with different governance structures. In terms of the review, the work of this Board has set the framework for how this has been looked at. At GM level governance, there has been an agreement that 3/8 groups will come under leadership of the Trust Provider Collaborative, but we need to make sure that each group looks at the whole system and pathway. Groups are now asked to do 3 key things: review/reflect on membership and governance, the scope (looked at over next few months) of what's happening nationally in GM and operationally – as planning for 25/6 is developed. We will reflect on this and how it dovetails into the GM operational plan. 3<sup>rd</sup> is around finances and how they are used. This element is clear with this group.



	<p>There might be a change in how we dovetail into GM governance, GM ICB has agreed we will feed all system groups into the Executive Committee – this already exists as a group but is not constituted in a way that allows it to do this work. Going to look at this group, membership and ToR before saying all the groups must report into it. Work is being done by the ICB and we are linked in – going to the ICB Board for agreement in January 25. VS has requested to come back to Cancer Board in January 25 and talk this through the suggested constitution. Will work with COR and Alliance colleagues to feed back into the ICB about this Board and how it runs. Need to provide evidence to the ICB in terms of actions of this piece of work to then be fed back to NSHSE.</p> <p>SL made a note for the Board that she has linked in regarding the systems programme workforce update delivered at the last board. Asked to define the top 3 workforce priorities and link that in. VS mentioned that as part of 25/6 planning, making sure what's happening is linking in together and in one room.</p> <p>TT added that accountability of the Executive Committee to the ICB is bilateral, feed into each other.</p>
<b>Decisions, actions, and responsibility</b>	VS to come back to January 25 board with an update on System Board Review/suggested constitution of Executive Committee

### 3. Evaluation of the digital Remote Monitoring System (dRMS) in GM for Personalised Stratified Follow up (PSFU).

<b>Discussion Summary</b>	<p>Andrea Webber (AW) presented from slides shared previously, taken paper as read.</p> <ul style="list-style-type: none"> <li>Summary of the paper is to evaluate the impact of using a dRMS, and inform the Greater Manchester Cancer Board in order to determine the benefits of retaining a dRMS system in the future for the safe and effective delivery of PSFU</li> <li>Had great feedback on everyone using across GM, one dataset across GM and an in-house system manager to be able to make changes in house. Work closely with all staff to make the usage of the system as smooth as possible. Nearly connected 40 interfaces across GM. Having this allows us to deliver on the deliverable. PSFU is now BAU – dRMS is just one part but is the part you can safely track patients on.</li> <li>Mainly a qualitative evaluation, cancer pathway for most patients is over 5 years so don't have data over a long enough period of time for quantitative but have done some projections.</li> <li>Colorectal been going for 18 months and have been able to repurpose several clinics and save a log of nursing time. CNS' appreciate having a safe system to use and virtual surveillance requesting clinic is now has a dedicated clinic once a month to make sure all scans are requested.</li> <li>PSFU using a dRMS main evaluation findings: Reduction in risk of losing patients to follow up, faster normal results reporting to patients, removal of paper and spreadsheets for tracking, increased staff morale in having the use of a secure</li> </ul>
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	<p>robust system that can be relied upon , better patient experience and use can be expanded into other areas (tracking system, so if it can be tracked on a pathway it can be used).</p> <ul style="list-style-type: none"> <li>• CS mentioned that with colorectal cancer have large proportion diagnosed at stage 1 and 2. Increasing with bowel cancer screening programmes. Have follow ups same as people with advanced cancer so need to stratify – when scan is done do not need to bring them in to the system tell them scan is clear. Should have access to a virtual clinic to access healthcare resources and contact staff with any issues. System is personalised care and colorectal cancer fits nicely as more and more patients with early stage. Fits in with health economics and health care, enough evidence on risk profile and patient choice. Bit of hesitancy as people are used to one system but evidence enough that this is what we should be doing.</li> <li>• AW concluded that those interviewed were all supportive of using, provides appropriate safety netting and quality of care, shows we can deliver on planning guidance and can roll it out at scale. Renal is almost ready to stratify then lung. More projected costs to be made but potential for future cost avoidance as freeing up space on pathways.</li> <li>• The Board is asked to approve the evaluation findings and support the recommendation of the evaluation that the NHS Trust organisations in GM need to continue its use of a dRMS for the delivery of PSFU from April 2025 onwards.</li> </ul> <p>SaT mentioned that this is great from a primary care angle to be assured there will be a follow up. Need to be careful overstating where we are at – have still never received an end of treatment summary. Still a way to go in the personalised care space.</p> <p>CG from a clinical point of view, ran PSFU in breast since 2016 and support this in terms of how we need a follow up system as it is unsafe to follow up on spreadsheets. Moving care away from necessary follow up for low grade cancers is great for long-term plan. Must be careful to not overstate the financial implications, already running this in clinic so need to be clear we aren't saving money we are making it safer. Went from having 5 ten minutes appointments to a single 1 hour so did not save time in breast, but improved quality. SaT mentioned could save time in primary care but this is hard to quantify.</p> <p>BS spoke from perspective of a patient, having to attend in person appointment can be a waste of patient and clinic time. Booking a patient that is unneeded causes unnecessary stress and anxiety on the patient. CS responded that see this all the time with patients, modern generation want to get on with things – if we have evidence that we can stratify patients it fits in.</p> <p>RP argued it adds value rather than delivers savings. Can't measure savings as such but they will be there.</p> <p>YS entirely supportive particularly from a patient point of view, disastrous when patient is lost to follow up. RS mentioned should emphasise patient safety in the evaluation. NF mentioned from a patient perspective some need to come in for that face-to-face appointment and need to include this patient cohort.</p>
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<b>Decisions, actions, and responsibility</b>	dRMS paper acknowledged and recommendation approved by the Board. Acknowledged that updates need to be made to reflect comments on financial savings before sharing wider.
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4. Health Inequalities	
<b>Discussion Summary</b>	<p>Dan Clark presented slides circulated previously.</p> <ul style="list-style-type: none"> <li>EIA process is being changed to a 2 stage process, more thorough and more fitting for more complex programmes. Talk Cancer attendance is down compared to previous years so will look at how this will work going forwards.</li> <li>Health inequalities training has been developed using the Cheshire &amp; Merseyside Cancer Alliance 123 approach. One session has been delivered so far alongside the cancer academy with another planned for December. Started offering to individual teams in trusts – if any members have teams interested then happy to come and deliver that.</li> <li>Following the National Voices insights report and CRUK Local CAM+ pilot, an action plan is being produced to incorporate findings and recommendations from both, as part of this a comms campaign will be created about primary care being open and approachable to those with cancer symptoms.</li> <li>Linked in slides to impact report for 1<sup>st</sup> round of CSE grants. 22 expressions of interest for round 3 with 12 invites to make a full bid.</li> </ul> <p>RH asked around access to genomic testing in the region, can we link in at to see what we can support with and what you can support us with. DC agreed, interesting conversation to have.</p> <p>AR asked if patients are aware of different modes of access to appointments? Not just telephone. DC responded we need to work on giving people the confidence, skills, and ability to approach, and a primary care ready to act upon the information.</p> <p>RP mentioned that as a system want 75% diagnosed, shouldn't accept 84% being able to contact their GP as that means 16% not contacting GP's or can't contact. DC responded not ignoring this but the 84% figure is potentially higher than the information we have from National voices, but this has the nuance – if you ring with cancer symptoms the response is improved. Difference doesn't shine between normal symptom and red flag symptom. Had innovation piece of work in Trafford, messaging around if you have these symptoms we must see you.</p> <p>BS raised that GP practice used to be phone call only at 8am, system of online forms now works well. DC responded first part of action plan is making sure we have a primary care system prepared, working actively in terms of quality improvement and certainly an area we are looking at. SaT iterated trying to look at different ways of getting into primary care, as the service is so much more pressured, we need to look at different ways.</p>



<b>Decisions, actions, and responsibility</b>	<p>DC/RH to link in regarding access to genomic testing in the region from a Health Inequalities perspective.</p> <p>DC to share paper with membership, to go out alongside Summary &amp; Action log.</p>
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## 5. Commissioning Intentions

<b>Discussion Summary</b>	<p>Ali Jones (AJ) presented slides circulated previously.</p> <ul style="list-style-type: none"> <li>The GM planning process for 25/26 has already started. AJ and LGD are involved in this process as the cancer alliance representatives. AJ is a member of the GM commissioning oversight group linking in with localities and the GM commissioning process. Work has commenced on understanding and demonstrating the entirety of the GM programme funding, using cancer as the first example. Working with FD to look at contracting and service specifications to support the Personalised Care programme.</li> <li>Commissioning intentions – In preparation as part of the 2025-26 planning round and with input from the Cancer Alliance for the cancer elements. Presented on slide.</li> </ul> <p>TT asked if we have an idea on what amount of diagnostic capacity needed next year etc. LGD mentioned there will be an expected amount of uplift, indicative figures to start off with about where we expect to see efficiency etc. recommendation to ICB colleagues is programmes are involved in confirm/challenge programme directly.</p>
<b>Decisions, actions, and responsibility</b>	<p>Board members to give feedback on Commissioning Intentions draft.</p>

## 6. Personalised Care

<b>Discussion Summary</b>	<p>Freya Driver presented from slides circulated previously.</p> <p>FD updated leading on from AJ's update previously, first deliverable on track – in the process of translating into commissioning intentions for next year. Service specification shared with NW colleagues as they are interested in this approach to follow the first planning ask as there is not much guidance nationally.</p> <p>As part of personalised care dashboard will start to include PSFU performance data from Infoplex.</p> <p>Participated in national PSFU snapshot data request.</p> <p>Psychosocial improvement plan – ThinkWell project underway, recruiting for clinical posts at GMMH - successfully appointed to one post last week and now working with BI team to identify data to baseline access to appointments.</p>
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	<p>Gap analysis 80% complete - education for staff and patients on importance of keeping physically active from the point of diagnosis can have on treatment optimisation emerging as key gap. Attended Cheshire and Merseyside meeting around this, they have found a lot of similar gaps from their mapping and a lot of work can do together on key messaging.</p> <p>SaT stated benefits of programme around exercise part of deliverable, ties in with so many other parts of the system and GM Cancer as a leader. VS shared all the benefits of exercise are not just cancer – area where it is important that we are linked in with all the other parts of the system. Good example in cancer on how this works.</p> <p>TT recognise value of psychosocial aspect and the challenge of recruiting. FD responded we provide part funding, but line management of the posts sits within GMMH. This is why initial agreement of the pilot was challenging (getting engagement and buy-in from the mental health provider) but is important to get this engagement as they will be delivering the pathway.</p> <p>AR raised a query around a patient asking around something specific between dementia/cancer –awareness etc. FD responded that will be captured under Live Well With Cancer, broad term of health and wellbeing support. Working with ICB Person-centred Care team as they have access/links with social prescribers. Important part is identifying these services and links.</p>
<b>Decisions, actions, and responsibility</b>	None noted

## 7. Early Diagnosis

<b>Discussion Summary</b>	<p>AJ shared slides circulated previously.</p> <p>Shared data, continue to track progress against 75% standard, at the alliance level we have maintained position of 13<sup>th</sup>, previously 16<sup>th</sup>. Very close to England position with latest data. Data is available showing benchmark using demographics of the population – if doing this 4/5 top sub-ICB areas are in GM. Helpful to show that to some extent we are doing the right work and is reassuring.</p> <p>Lung Aware Healthbot: promotion now seen around GM, encouraging people to think about their lung health and giving them information to have informed conversations with healthcare professionals.</p> <p>FIT - great strides made on use of FIT with primary care referrals, current position is 77% but know where areas of improvement needed so we are able to have targeted conversations. Colorectal ThisVanCan launches on Thursday 28<sup>th</sup> November promoting messages about bowel health and screening. Will be driving around GM – collected data from BI team to find where late-stage diagnosis is prevalent, and this is used as the basis for the route planning.</p>
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	<p>Gynae pathway board: smaller scale van for ovarian cancer, when plotting the route where late-stage diagnosis is common it is more affluent areas and is somewhat of an outlier. Working with Diane Oxberry Trust.</p> <p>ED strategy in collaboration with Edge Health: received a draft strategy and are in the process of refining, going to ED board on Wednesday 27<sup>th</sup> November. Development of strategy over 6 months has been picked up as we go along, focus on timely presentation, primary care pathways, innovation, screening, address variation.</p> <p>RS mentioned more interest nationally on where improvements are being made, one of the major points in the next 10-year plan.</p>
<b>Decisions, actions, and responsibility</b>	None noted

## 8. Faster Diagnosis & Operational Improvement & Treatment Variation

<b>Discussion Summary</b>	<p>Lisa Galligan-Dawson shared slides circulated previously.</p> <p>The comprehensive papers and appendices were taken as read.</p> <ul style="list-style-type: none"> <li>Performance reported was based on Septembers published reports – The paper outlines performance against the planning trajectories, national CWT standards and includes national and regional comparisons. Paper includes all figures. It was reported that GM are just under the FDS and 62 day RTT trajectories in September, with 2 risks in NCA related to the delivery of FDS due to the skin pathway and from a 62-day perspective in relation to MFT. Latest predicted figures put us on track in October and November, at system level to deliver year end. LGD reported that she had attended with a patient representatives forum last week to discuss operational performance. The patient group voiced the importance of cancer waiting times to them, driving improvement and achieving constitutional standards. They expressed that they want more of a voice around this in forums and this is something for us to support them with, and for this Board to note.</li> <li>Comparison to NW/national position – LGD reminded members that the 31-day position might look positive, but they are consolidated and aggregated figures. Our combined figures</li> <li>would be expected to be higher as we deliver the most radiotherapy in the country. Reviewing 31 DTT for first treatments is therefore essential to determine system improvement</li> </ul> <p>Version 12.1 of CWT is currently out for consultation, with a number of relatively significant changes proposed. Indicative impact is described in the paper and a full evaluation of this will be issued once the final guidance is published. The Board were asked to consider any feedback and encourage feedback from their representative groups. The final version is expected to be published late January 25 / early February 25 for implementation from 01 April</p>
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	<p>25. LGD shared a new system Mutual Aid policy in the pack, encompassing elective, diagnostics and cancer. It was described as an iterative document, with a move to more proactive use of system capacity. The Board were asked to approve the policy. The policy was approved, with consideration that the policy will be iterative. RS stated that it was encouraging to see policy here and that feedback from attendees at the Board in their respective groups and organisations should be from a cancer point of view to encourage the Mutual Aid approach.</p> <p>LGD agreed the policy is a starting point, and that we have demonstrated benefit through our own work in terms of single queue etc. In terms of surgery, there has been encouragement to the system about the use of mutual aid; not moving cancer patients at that point in the pathway but moving more routine patients to facilitate more cancer being delivered. The use of Mutual Aid in the future is to look in terms of assets across the system and how we can use them to allow organisations to deliver more equal access for their patients.</p> <ul style="list-style-type: none"> <li>An update paper was included in the pack for the artificial intelligence diagnostic fund AI project on chest x-ray. Progress was reported as positive, with backlog in Chest xray backlogs reducing and the AI allowing prioritisation of chest x-rays for reporting. The technology narrows field from chest x-rays with a suspicion of cancer from ~1/8000 to ~1/21 . Work is early in its journey so is for this Board and organisations and groups represented to encourage to use the prioritisation functionality. Findings reported through internal trusts and systems.</li> </ul> <p>RS mentioned national discussion around FDS performance, and the requirement to focus on the 'cancer diagnosed' cohort. LGD confirmed the profile of this locally, and mentioned the work completed to track live/published data down to pathway level. In GM the cancer confirmed cohort performance sits between 49-52%. LGD explained that the GM stretch target of 83% for overall FDS this year was to drive improvement in the cancer confirmed cohort. Latest position from September is 49%.</p>
<b>Decisions, actions, and responsibility</b>	Mutual Aid policy acknowledged and approved, to feed back into next iteration.

9. Performance Improvement Plan (ICB Undertakings)	
<b>Discussion Summary</b>	Taken to GM Cancer Programme Assurance Group meeting and included for approval of the Board.
<b>Decisions, actions, and responsibility</b>	Paper acknowledged and approved by the Board.



10. Papers for Information	
<b>Discussion Summary</b>	Papers were noted.
<b>Decisions, actions, and responsibility</b>	None noted

11. AOB	
<b>Discussion Summary</b>	<p>SP recognised the work of the GM Cancer Alliance at the Cancer Alliance Leadership Forum in London; SP was told that the GM Cancer Alliance is regarded as the most mature alliance in the country who are being looked at to guide some of the strategies. Asked about AI and GIRFT. SP reiterated that we should be proud of the work delivered by colleagues across GM.</p> <p>Well done to teams shortlisted for HSJ awards, particularly LGD and ME for single queue, receiving highly commended in their category.</p>
<b>Decisions, actions, and responsibility</b>	None noted

The next meeting is scheduled for 27<sup>th</sup> January 25, at:

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



Log Number	Date Created	Status (Open/Closed)	Details of actions agreed	Action Lead	Due Date	Comments
7	30/09/24	Closed	PJ to link in with SL regarding Community Services Review/ACCEND	PJ/SL	25/11/24	
9	30/09/24	Closed	Any questions around Performance Improvement plan highlight report shared with LGD	All	25/11/24	
8	30/09/24	Open	PJ to escalate issue around psycho-social support improvement plan to Pennine colleagues	PJ	27/01/25	
10	25/11/24	Open	Dermatology programme requiring escalation with representation from Cancer Board colleagues.	RS/All	27/01/25	
11	25/11/24	Open	VS to come back to January board with an update on System Board Review/suggested constitution of Executive Committee	VS	27/01/25	
12	25/11/24	Open	DC/RH to link in regarding access to genomic testing in the region from a Health Inequalities perspective.	DC/RH	27/01/25	
13	25/11/24	Open	DC to share Impact Report paper with membership, to go out alongside Summary & Action log.	DC	27/01/25	Paper shared with admin
14	25/11/24	Open	Board members to give feedback on Commissioning Intentions draft.	All	27/01/25	

