

Greater Manchester Quarterly Reporting Template 2024/25

Part 1 – Narrative updates against plans & milestones

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Notes on how to use this template

There are two parts of the quarterly reporting template, which mirror the Delivery planning templates:

PART ONE This Word template: for Narrative updates against plans and milestones, and risk ratings

PART TWO An Excel template: for Funding and Success Measures (see master copy [here](#))

These templates should be completed together, in full and uploaded to the relevant Alliance folder on [the workspace](#) for review by Regions and the National team. Please note that we cannot review returns with significant gaps or which have been returned late.

The same templates will be used for each of your quarterly submissions throughout the year, we will not produce a new version each quarter. As such, please always update the most recent version from your Alliance folder on the workspace. You do not need to wait until the formal commission date to begin populating your templates either.

Step	Q1	Q2	Q3	Q4
Quarterly return commission	24th June 2024	23rd Sept 2024	23rd Dec 2024	24th Mar 2025
Deadline to upload completed returns to the workspace	24th July 2024	23rd Oct 2024	22nd Jan 2025	23rd April 2025

PART ONE REPORTING TEMPLATE - Cancer Alliance Delivery: Narrative updates and milestones

For the most part, narrative updates should clearly and concisely explain:

- 1) How delivery is going is line with your agreed 24/25 Delivery Plan.
- 2) How allocated funds from your SDF (per the amounts set out in Part two) have been used in the last quarter.
- 3) Why the quarterly position may be different to the trajectory submitted in your plan.
- 4) How far the milestones outlined in your Delivery plan have been met, or whether these need to be changed and why.
- 5) Progress being made to address health inequalities

Alliances should complete all the peach-coloured text boxes. The text boxes will expand as you type.

Please refer to the [Planning Pack 24/25](#) for a reminder of the categorisation of deliverables for the year ahead. For programme deliverables in the following categories, narrative quarterly updates only need to be brief, or respond to the specific prompts given in each section:

- Category 1 ('*Locally driven programmes led by Cancer Alliances*') - Timely Presentation*, Primary Care Pathways*, Early Diagnosis Initiatives (Innovation)*, Health Inequalities*, Screening, Living With and Beyond Cancer, People and Communities, Experience of Care, Treatment Variation (SACT), Workforce
- Category 2 ('*Innovation programmes*') - Community Pharmacy
- Category 3 ('*Programmes delivered in partnership with other programmes or teams with support from Cancer alliances*') – Pancreatic cancer (EUROPAC), Liver pilots (Community Liver Health Checks)

*Please note that Category 1 projects addressing local early diagnosis priorities have specific information requests which must be reported in this template. This is so that updates can be provided to the NHS oversight framework, whereby progress against early diagnosis at a system level is being tracked.

There is optional space at the end of the template (grey boxes) if Alliances wish to update on other local projects being delivered using cancer service development funding (SDF), or progress being made to transfer programmes to BAU (Colon Capsule Endoscopy, Capsule-sponge, Lynch and NSS).

Risk reporting in this template

The risk log that was previously in the Part 2 Excel template has moved to this document following feedback that it would be easier to report and review the risks and delivery progress in the same place. There is an overall Alliance-wide risk section to report on page 4, and then each workstream has its own space for risk reporting.

Please enter the risk rating from one of the options below, and briefly explain the nature of the risk and mitigations taking place – these should be overwritten each quarter as necessary.

Green	Delivery on time, to cost, and quality appears highly likely. There are no major outstanding issues or significant threats to delivery at this stage.
Amber	Successful delivery appears probable however constant attention will be needed to ensure risks do not materialise into major issues threatening delivery
Amber/ Red	Successful delivery is in doubt with major risks or issues apparent in several key areas
Red	Successful delivery appears to be unachievable. There are issues which at this stage do not appear to be manageable or resolvable

Quarterly overview 2024/25

Use this section to highlight key achievements or challenges from the most recent quarter.

	Major achievements	Key concerns
Q1	<ul style="list-style-type: none"> • Tele-dermatology live, with every Trust having access • Significant progress regarding implementation of ACCEND – a Cancer Education and Development Lead started in post to lead this work and led the launch of the GM Community of Practice to support system-wide implementation. 	<ul style="list-style-type: none"> • Conflicting priorities for provider Trusts. Significant challenges to delivery of elective long waiters, DM01 and cancer shares the physical capacity and workforce. In addition, the significant financial pressures in GM are impacting the ability for Trusts to deliver additionality needed and there is a restriction in headcount and so there are recruitment challenges. • Risk of industrial action on operational performance
Q2	<ul style="list-style-type: none"> • Evaluation to date of the Single Queue Diagnostics system (SQD) has shown very positive outputs, gaining support for further expansion and longer term procurement 	<ul style="list-style-type: none"> • Conflicting priorities for provider Trusts. Significant challenges to delivery of elective long waiters, DM01 and cancer shares the physical capacity and workforce. In addition, the significant financial pressures in GM are impacting the ability for Trusts to deliver additionality needed and there is a restriction in headcount and so there are recruitment challenges. • NICE current evaluation does not support autonomous use of skin analytics AI
Q3	<ul style="list-style-type: none"> • Implementation of PMB pathway via primary care algorithm. • Favourable Health Economics assessment of SQD • Completed pilots for Ovarian Cancer One Stop Pathway and H&N Radiotherapy Pathway • Significant progress has been made with the implementation of ACCEND with over 600 people logging capabilities on the GM ePortfolio, which hosts the only digitised version of the framework. All relevant staff groups are now accessing the framework. 	<ul style="list-style-type: none"> • NICE current evaluation does not support autonomous use of skin Analytics AI– update expected in Q4 • NHSE AI funding excludes any financial support for second read • Significant system challenges: finance, DM01 and elective long waiters, adding greater risk to the delivery of operational performance • ACCEND will not become BAU by end of March 2025, acknowledged by the national team. • Inductions / appraisals will not be aligned to ACCEND by end of March 2025.

	<ul style="list-style-type: none"> GM was invited to share their work at the National Community of Practice in recognition of progress made. 6 alliances are now utilising the GM ePortfolio, with 4 more in discussion. 	<ul style="list-style-type: none"> Staff not being supported to take time focus on development.
Q4		

Risk log 2024/25

You can use this section to log any Alliance-wide risks that may impact delivery, as well as mitigating actions that are being taken. Risks to individual deliverables should be logged in the workstream risk sections below.

	Risk Description for the Quarter (Please add or edit any ongoing or anticipated Alliance-wide risks)	RAG Rating	Risk Mitigation (Please outline how you are mitigating/will mitigate the risk)
Q1			
Q2			
Q3			
Q4			

Quarterly Report against Delivery Plan 2024/25

1 Workstream: Cross-cutting

1.1 Alliance Capability

Deliverable	<ul style="list-style-type: none"> In response to the Alliance capability needs and informed by the Cancer Alliance self-assessment (completed in 23/24) and associated stakeholder feedback, produce an organisational development action plan to prioritise, implement and evaluate capability improvements.
Success measures	<ul style="list-style-type: none"> Cancer Alliances should measure their own progress against the 'What makes an effective Cancer Alliance' criteria. The quarterly reporting process can be used to update on progress, by exception, as well as risks to Alliance capability. This includes capacity to deliver, such as gaps in established workforce and challenges with recruitment.

Narrative quarterly updates *(Please provide updates on progress against the 'What makes an effective Cancer Alliance' report criteria, progress on development and implementation of organisational development plans, and the impact that activities have had on improving capability area identified)*

Q1	<p>Patient Outcomes – the recently appointed GM Cancer Clinical Lead for Health Optimisation and Clinical Outcomes has begun working with the Pathway Board Leads in utilising data to identify, monitor and impact areas of need. A projects tools training day for project managers/programme leads has been held which included project evaluation/benefits realisation. The Alliance has also delivered a lunch and learn for the team regarding the use of the recently introduced health economics framework so that the tool is embedded.</p> <p>Organisational Development – A date in early October 24 has been identified to hold the biannual team engagement event to help to continue creating a positive culture, improving employee engagement and experience. The established, staff-led EDI working group is working well and is underway in delivering the annual plan of associated activities which are promoted at the monthly team meetings and 'coffee and cake' catch ups. The Cancer Alliance has appointed a new Medical Director in Q1.</p> <p>Approach to Assurance – A review of the system governance is underway, and the ToR for the GM Cancer Board have been refreshed to clearly define roles and responsibilities and reflect the current governance and assurance processes. The Cancer Alliance has been reviewed as part of a wider ICB system board review and recommendations awaited.</p> <p>Relationships and Influence – In order to improve collaboration across the cancer system, The triannual Cancer Lead Forum was held in June 24 and the Pathway Lead event in July 24. A series of 10 locality visits has now been completed and a report listed on the Cancer Board agenda for 29th July 24. The Cancer Alliance delivered a 2024 GM Cancer Conference in May 24 which has received AMAZING feedback.</p> <p>Delivery - The Cancer Alliance is about to begin the review of team structures and skills mapping exercise – this will be carried out in Q2 with consideration given to succession planning.</p>
Q2	<p>Patient Outcomes – the GM Cancer Clinical Lead for Health Optimisation and Clinical Outcomes is now presenting on a quarterly basis at the Cancer Alliance Programme Assurance Group on progress of the Clinical Outcomes Data Strategy for Cancer Group which is supporting the identification, monitoring and impact areas alongside the Pathway Boards. Expressions of interest have just been requested as part of the work of the Cancer Clinical Outcomes and Data Group, to run a single feasibility study to understand the</p>

	<p>resource required (both BI and clinical) to answer questions that utilise the registry data, as well as learning more about how to use this new dataset. This learning will be used to inform the future approach to managing requests that utilise the registry data.</p> <p>Organisational Development – November 24 will see the biannual team engagement event to help to continue creating a positive culture, improving employee engagement and experience. The first meeting to develop a 5-year Cancer Alliance forward plan has been held with a follow up meeting scheduled for November. A strength-finder activity has been completed with all members of the GM Cancer Alliance and has been reviewed on an individual basis but also with sub-teams. Some Cancer Alliance team members are benefitting from access to coaching and NHS Leadership Academy Programmes e.g Elizabeth Garrett Anderson Programme.</p> <p>Approach to Assurance – A review of the system governance and assurance processes is complete with the necessary changes made to ensure clarity on roles and responsibilities and maximise effectiveness. The Cancer Alliance has been reviewed as part of a wider ICB system board review and recommendations presented. This review was led by the GM Cancer Alliance Managing Director. An action plan is in development which will deliver on the recommendations. The Cancer Alliance Peer review/Quality Surveillance process proposal was presented and approved at GM Cancer Board in July as was the Cancer Alliance ‘plan on a page’ outlining the delivery plan/activities of the organisation in delivering the operational planning guidance.</p> <p>Relationships and Influence – In order to improve collaboration across the cancer system, the next triannual Cancer Lead Forum and annual education event is scheduled for November 24 with the Pathway Lead event scheduled for that same month. The Cancer Alliance are in the process of scheduling the annual cancer locality meetings with the first meeting scheduled for November.</p> <p>Delivery - The Cancer Alliance has begun the review of team structures and skills mapping exercise. This has identified the need for a Cancer Alliance Lead Nurse and a JD/person specification is being worked up. NHS GM has identified the importance of developing of those staff sitting just under the ICB Executive team so the Cancer Alliance Managing Director will be part of the Executive Leadership Team who are currently participating in a diagnostic exercise to understand what people would want from development sessions.</p>
Q3	<p>Patient outcomes – Expressions of interest for a feasibility study using cancer registry data were requested by the GM Cancer Clinical Outcomes and Data Group. Following review and scoring of the Eols, a project has been selected to explore the feasibility of utilising the registry data to identify patients with metastatic breast cancer. Currently this cohort cannot be well identified, due to inconsistent recording of patients who do not have metastatic disease when the first present with cancer, but subsequently develop metastases. The project is intended to address a clear clinical need in addition to developing local skills in utilising the registry data. This learning will be used to inform the future approach to managing requests that utilise the registry data. The project begins in mid-January 2025. In parallel, BI colleagues have performed an initial analysis of patient survival using the registry data, as a proof of concept and learning exercise, in order to develop the ability to look locally at survival for key patient cohorts to inform future projects and directions.</p> <p>Organisational Development – Biannual team engagement day held in November which received positive feedback. An action plan has been developed following feedback from the team and these actions are being jointly owned. The second meeting to develop a 5-year Cancer Alliance forward plan has been held with a draft anticipated in Q4. Following the completed strength-finder activity, the Alliance has supported an influx of study requests to ensure staff development. The staff-led EDI working group is currently reviewing progress against their annual EDI and the monthly team meetings including the ‘coffee and cake’ catch ups continue and are well received by staff members.</p>

	<p>Approach to Assurance –The Cancer Alliance received an update at GM Cancer Board in November on the ICB system board review of which the Alliance was a part. Assurance has been given that there are no changes recommended for the Cancer Alliance to enact. impacting on the and recommendations presented. A Peer review/Quality Surveillance forum will be held in January to review with the cancer system, the success of the GM process that has been introduced. The forum will allow providers/place to present 3 challenges highlighted by peer review and 3 areas of best practice to share which will help inform thematic analysis for GM. The GM Cancer Alliance and Strategy and System Risk Assurance Groups continue to be held on a monthly basis which feed into GM Cancer Board</p> <p>Relationships and Influence – The triannual Cancer Lead Forum, Biannual Pathway Lead event and annual education event were all held in Q3. The Cancer Alliance have now scheduled all 10 locality meetings with the first meeting to be held in Q4. Planning has begun for the next flagship Greater Manchester Cancer Conference which will take place in November 2025</p> <p>Delivery – Following the review of team structures and skills mapping exercise, a number of fixed term contract roles will be terminated at the end of Q4 but alternative roles introduced to ensure we maintains the capacity and capability to deliver the eagerly anticipated planning guidance. Due to the pressure in NHS the diagnostic exercise to understand the development needs of those within ICB Executive Leadership team (including the Cancer Alliance Managing Director) has been delayed.</p>
Q4	

Risks (Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter)				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter)				

1.2 Workforce

Deliverable	<ul style="list-style-type: none"> Facilitate the implementation of the ACCEND Career Pathway, Core Cancer Capabilities and Education Framework in providers for non-medical cancer workforce roles
Success measures	<ul style="list-style-type: none"> <i>Narrative updates should be provided quarterly.</i>

Narrative quarterly updates *(Please outline progress against each activity set out within the 24/25 delivery plan, highlighting if these activities have been delivered, if they are still in train, or if there are any challenges or delays expected.)*

Q1	<ul style="list-style-type: none"> 100% of providers submitted action plans outlining how they will implement ACCEND. These are live documents and will evolve overtime as some of the activity was limited and dependant on recruitment of additional resource 100% of providers attended Q1 review meetings to discuss progress against action plans A GM Community of Practice was established in Q1. 86% attendance (6 out of 7 providers). 7 CNS' and 1 AHP attended, providing positive feedback. We anticipate numbers will increase following Q1 meetings with Lead Cancer Nurses, wider promotion and more targeted work with CNS and AHP groups around use of the framework 3 Cancer Education and Development Leads will be recruited to support implementation across all GM providers to reduce inequity across the conurbation. 1 started in post in Q1, 1 was recruited and due to start in Q2, and the third post is live. The Cancer Education and Development Leads will target providers which serve more disadvantaged communities as shown by the data provided by the GM Cancer Health Inequalities Programme Lead via the inequalities data hub e.g. Manchester, Tameside, Oldham. Work has commenced at Tameside and ACCEND Mentors have been identified to support rollout across all CNS teams An ACCEND AHP advisor was recruited and started in post. A pilot site has been identified and plans in place to commence this work in Q2 To support implementation across the registered workforce and to support diversifying the Cancer CNS workforce the framework will be piloted with international nurses. 10 nurses have been recruited across two localities, all have completed phase 1 of the Aspiring CNS programme – Foundations in Oncology training programme, and mentors within CNS teams have been identified. Phase 2 will consist of different placement models with cancer teams. A baseline survey has been created to assess current competencies Task and finish group established to lead standardisation of the Cancer Care Coordinator job description, collation of existing JDs has commenced and a Lead Cancer Nurse identified to lead this work 1 provider (14%) has aligned their induction programme to ACCEND and piloted this with 4 new starters. This has now been shared with all other providers as an exemplar 1 provider (14%) has piloted incorporating ACCEND into appraisals
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	<ul style="list-style-type: none"> • 0 providers have aligned job planning however, discussions have commenced regarding this, and a model developed at one provider organisation has been shared more widely • There has been a 63% growth in the number of users of the ACCEND framework on the ePortfolio (n=316). There is currently a data error with one of the providers however, excluding the Christie, 44% of CNS' are now utilising the ACCEND framework on the ePortfolio, and 15 AHPs (% unknown) • There are 2 new tumour specific ACCEND frameworks live on the ePortfolio • Training needs analysis utilising ePortfolio data to identify gaps in capabilities registered: data gathering in progress - dashboard to review full capabilities logged on track for going live in September, this will help to identify future training and education needs • Online webinar to support line managers to implement ACCEND: a webinar has been recorded, shared with SMEs for feedback and currently being finalised ready to launch in Q2 alongside a complementary handbook • Working Group established to create a data dashboard for the Cancer Support Worker workforce. ESR coding workaround has been agreed. 2 sites have completed the data cleanse using the new coding. Dashboard development has commenced.
Q2	<ul style="list-style-type: none"> • 85% of providers attended Q2 review meetings to discuss progress against action plans (one provider didn't attend due to sickness) • The GM Community of Practice continues to take place monthly with good attendance across all providers. A Cancer AHP community of practice was also established this quarter and the alliance was asked to share the significant progress made at the National ACCEND Community of Practice • All 3 Cancer Education and Development Leads are now in post to support implementation. The GM Cancer Alliance Lead has developed implementation workshops to introduce all three components of ACCEND. These have been piloted with one provider and will be rolled out across GM throughout Q3 and Q4 • The ACCEND AHP advisor is no longer in post however, this work is being taken forward by the GM Cancer Alliance Cancer Education and Development lead, with work already underway with AHPs in one locality • Implementation of ACCEND across International Nurses (registered workforce) continues to progress. An education day was held in Q2 to increase awareness and understanding of ACCEND and practical support on how to use the framework. INs at one site are currently on rotational placement with cancer teams. The second site is due to start in Q3 • The final draft of the standardised Cancer Care Coordinator job description has now been shared with key stakeholders. This will be finalised in Q3 • All providers are focusing on implementing ACCEND with new starters within their organisation starting with aligning inductions. One provider has a live aligned induction, one is currently developing a new induction package, with 4 other providers due to follow in Q3 • To support embedding ACCEND as BAU, ACCEND mentors have been identified across 5 of the 7 providers. These will attend the implementation workshops in Q3 and 4 with a view to sharing learning across their teams • Aligning appraisals will now take place in Q4 once ACCEND mentors have been identified and implementation workshops have taken place

	<ul style="list-style-type: none"> • The number of users logging ACCEND capabilities on the GM Cancer ePortfolio has increased from 316 in Q1 to 454 (an increase of 44%). The number of AHPs using the framework has increased from 15 to 27. • Four new tumour specific ACCEND frameworks are live on the ePortfolio, taking the total to 6. No further frameworks will be developed until existing frameworks are tested and numbers accessing the frameworks is reviewed • Training needs analysis utilising ePortfolio data to identify gaps in capabilities registered: dashboard to review full capabilities logged has been delayed until Q3 • Online webinar to support line managers to implement ACCEND: webinar is now live and handbook has been finalised. Both have been shared with all providers to share with line managers to support implementation • Cancer Support Worker workforce data dashboard has been built. Data is currently being populated. This will be live in Q3.
Q3	<ul style="list-style-type: none"> • 100% of providers attended Q3 review meeting to discuss progress against action plans. Positive progress is being made across all providers however, ACCEND will not become BAU by end of March 2025. Full implementation across all three components will take time to achieve given the change in culture, infrastructure that is required. GM is a member of the National ACCEND steering group, and this challenge has been acknowledged by the national ACCEND team. • GM presented at the National ACCEND Community of Practice due to significance progress made locally, which was welcomed by other regions and led to a significant number of cancer alliances reaching out for advice and guidance post meeting. The GM CoP continues and was attended by 6 out of the 7 providers this quarter to share best practice. • Significant progress has been made with AHPs this quarter. Chief AHPs are supporting the rollout across AHPs starting with pilot groups (discipline specific). Groups have been identified in 3 localities and awareness sessions targeting AHPs have been taking place across all providers. There is also a dedicated AHP Community of Practice which is being utilised to raise awareness of ACCEND and dedicated ACCEND workshops at joint CNS / AHP away days. • Implementation of ACCEND across International Nurses pilot (registered workforce) – the pilot is now complete at Tameside with 100% completion. Evaluation will commence Q4. There was a delay with the Stockport pilot due to sickness however, INs have been reengaged and the project will launch 31st January with placements commencing in February (all INs had completed the educational component in previous quarters). • The standardised CCC job description is now at final sign off stage (slight delay due to lack of consensus on job titles, which has now been resolved), Navigator and MDT Coordinator JD standardisation has been initiated with leads identified. • To support embedding ACCEND as BAU, ACCEND mentors have been identified across 6 of the 7 providers. Implementation workshops have commenced across 2 providers. The remaining providers have dates planned in Q4 for implementation workshops. • Inductions are progressing across 6 of the 7 providers for new starters. To develop this further, work has commenced to develop and standardise GM pathway specific induction templates via the alliance pathway boards. This will be a focus for 25/26. • The number of users accessing the digitised version of ACCEND via the GM Cancer ePortfolio and logging capabilities has increased from 454 in Q2 to 646 this quarter (an increase of 42%). 7,200 capabilities have been logged and 658 pieces of education. Five other cancer alliances are now utilising the GM ePortfolio and discussions are progressing with 4 additional

	<p>alliances across England. This data provides good evidence that ACCEND is being implemented across the following professional groups ACPs, AHPs, Doctors, Nurses, support workers and students.</p> <ul style="list-style-type: none"> • Data is now available to provide insights into capabilities being logged / training being accessed / gaps however, a greater volume of data is needed over a longer time period to identify trends to influence future educational offerings. • The online webinar to support line managers to implement ACCEND has been viewed 393 views. There is also an infographic and handbook available on the academy website. • The CNS and Cancer Support Worker workforce data dashboard has been combined to make it easier for managers to access. This is currently being piloted. 6 out of 7 trusts have now completed the data upload for the CSW workforce.
Q4	

Risks (Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
<p>Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter)</p> <p>Due to the enormity of implementing ACCEND and the culture change this requires (seen nationally) all providers will not have aligned inductions, appraisals this year. The main focus has needed to be on laying the foundations i.e. identifying mentors (advocates), working with senior leaders to gain buy in to support staff to understand the three components, benefits, how to fit into daily practice etc. which requires a complete change in mindset and way of working.</p>				
<p>Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter)</p> <p>Work has been initiated on inductions and will continue into 25/26. Engagement with Chief Nurses and Chief AHPs has commenced and been positive to date to help drive this forward at an organisational level. Dedicated workshop with Chief Nurses and Chief AHPs planned in Q4 to address barriers as a system.</p>				

1.3 People and Community Engagement

Deliverable	<ul style="list-style-type: none"> Cancer Alliances to establish and maintain a people and community engagement approach to enable the diverse voices of communities to be heard and built into work programmes throughout the Alliance and in conjunction with local ICBs and Trusts.
Success measures	<ul style="list-style-type: none"> <i>Cancer Alliances should set own metrics to measure achievement of people and community engagement activities.</i>

Narrative quarterly updates (Please ensure to address only the deliverable related to People and Community Engagement, rather than anything that relates to the Experience of Care deliverable as this should be covered in in [section 5.3](#))

Q1	<ul style="list-style-type: none"> Patient and Carer Representatives featured heavily in the GM Cancer Conference and Awards: 15 patient and carer representatives attended, 9 joined on stage to present/take part in Q&A, 24 featured in patient videos. June quarterly engagement Coffee and Cake events (virtual and face to face) both well attended. Topics included personalised care, the GM Cancer Conference, a volunteer thank-you, and two Patient Representative showcases to encourage uptake of presenting at health and wellbeing events, and partaking in interview panels. Work continues with Magpie Communications to design recruitment materials to reach a wider audience within Cancer Voices Community/PPIE programme. Materials should be ready to disseminate in August. Training and education offers for reps: finalised the new online induction package for patient and carer representatives, continued development on an online module for healthcare professionals on effective PPIE Currently transitioning to a new provider to collect registration data from Patient and Carer Representatives when they sign up, and a database that allows us to monitor their activity, to improve the induction experience Series of creative workshops with Made by Mortals in June to create a bespoke audio story which will help to explore the purpose and benefits of personalised care interventions. Small community meetings held across all relevant groups Continued monthly meetings between PPIE Manager and PPV partners to support them in their role and align more closely with national team. Continued involvement in the development of a national guide for cancer alliances to use in the event of the death of a Patient and Carer Representative Promotion of CPES uptake through the personalised care board and delivery group
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Q2	<ul style="list-style-type: none"> September quarterly engagement Coffee and Cake events (virtual and face to face) both well attended. Topics included pathway updates, genomics, early diagnosis strategy update, PPIE recruitment campaign and one showcase from patient representative on gynae cancer awareness month. Work was finalised with Magpie Communications. We now have a full suite of recruitment materials (physical and digital assets including an animation) to reach a wider audience within Cancer Voices Community/PPIE programme. Launch has been delayed due to delays with our new volunteer registration form – we should be able to go live in October/November. Training and education offers for volunteers: Virtual ‘Talk Cancer’ workshop took place in September. Two new ‘meet and greet’ sessions for nine new volunteers took place in October as part of refined induction process. PPIE module for staff is now finalised – will go live on Academy as part of the website refresh, and embedded into staff induction. Other training being commissioned for rest of year. New registration form and database to collect personal information from new volunteers is ready, but due to delays with information governance, we are awaiting approval to go live. This is causing some delays to other projects as specified above. Series of creative workshops with Made by Mortals have now taken place, and bespoke audio story on personalised care interventions is currently being edited. Launch due to go live at the end of November. Small community meetings (expert by experience focus groups) held across all relevant groups (lung, skin, head and neck, OG and colorectal). New programme and pathway board forum set up to support volunteers who are members of our boards to communicate with one another, and understand common themes with regards to successes and challenges that can be fed up the governance structure to cancer board. Continued monthly meetings between PPIE Manager and PPV partners to support them in their role and align more closely with national team. Continued involvement in the development of a national guide for cancer alliances to use in the event of the death of a Patient and Carer Representative. Band 5 Project Support Officer supporting the PPIE team left their role at the end of September. Interviews for replacement took place, and successful candidate appointed (likely to start before the end of the yea
Q3	<ul style="list-style-type: none"> December quarterly engagement Coffee and Cake events (virtual and face to face) both well attended. Topics included pathway updates, genomics, early diagnosis strategy update, PPIE recruitment campaign and one showcase from patient representative on gynae cancer awareness month. Tenure review across all pathway and programme boards is in progress.

	<ul style="list-style-type: none"> • Small community meetings (expert by experience focus groups) held in Q3 for breast, lung, skin, head and neck plus new gynae small community established. This group had direct input into the Skin AI patient facing letters. • Launched new recruitment campaign in November to expand and diversify GM Cancer Voices Community. Presented to, and disseminated printed materials, to various workforce groups across GM. Paid advertising on socials and local press has led to over 34,000 engagements. Ten new volunteers registered since launch. • Workshops for tumour specific recruitment campaign are underway, working with our small communities to co-design. • Registration form now live for new volunteers. Existing volunteers will be asked to update their details on new platform in the next month. • Bespoke audio story demonstrating personalised care interventions featuring patients called 'my friend with cancer' is being launched in February 2025 as educational package. • Training and education offers: Three 'meet and greet' sessions for ten new volunteers took place in October. PPIE module for healthcare professionals is live on GM Cancer Academy and 65 people have enrolled. Induction module for new volunteers has 14 volunteers enrolled. Training video in production to explain pathway boards and small communities. • Band 5 Project Support Officer (Keisha) started in role in November to support work of PPIE.
Q4	

Health Inequalities updates *(Please provide a brief update with regards plans to address Health Inequalities as part of this work. Updates should focus on how the Alliance are gaining insight into what is causing health inequalities and developing solutions to overcome the barriers identified, as well as outreach work the Alliance is undertaking .)*

Q1	<ul style="list-style-type: none"> • In the design of our recruitment materials and campaign, we have involved a wide range of stakeholders including willing volunteers from the Cancer and Inequalities VCSE Network facilitated by 10GM, who have shared their feedback. This campaign is targeted primarily at younger people, people of different ethnicities, and people from all areas of Greater Manchester (including socioeconomically deprived areas), as we know we lack representation in these areas. Further consultation will be done with the VCSE sector on the final materials before they are launched. • As referenced in section 4.6 – there are grants available to the VCSE sector to address inequalities in early diagnosis.
Q2	<ul style="list-style-type: none"> • Returned to the Cancer and Inequalities Network, attended by a range of VCSE organisations, to thank them and show how their feedback has influenced the final recruitment assets. • As referenced in section 4.6 – there is a further round of grants available to the VCSE sector to address inequalities in early diagnosis. • The PPIE team has supported the development of the early diagnosis strategy through engagement with volunteers who have fed lived experience into the considerations, as well as engagement with the VCSE sector.

Q3	<ul style="list-style-type: none"> We are continuing to attend cancer support groups and health and wellbeing events across the region, speaking with patients about their experience and feeding this back to relevant teams, whilst promoting the opportunity to volunteer with us. We are continuing to engage with the Cancer and Inequalities network as required to understand how we can better engage and reach certain communities via voluntary and community organisations.
Q4	

Risks (Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) As specified above, our information governance team are seeking assurance from the provider we have commissioned to develop a new registration form and database that they meet all requirements (e.g. how and where they store data). This is preventing us from going live, and is having a knock on effect on the completeness of our induction process and delaying the launch of our new recruitment campaign.				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) Continuing to work with information governance and the provider to speed up the approval process. Continuing to support/induct our new volunteers who join the Cancer Voices Community, and explaining that we will retrospectively ask them to complete a registration form once available.				

2 Workstream: Faster Diagnosis and Operational Performance

2.1 Operational Performance

Deliverable	<ol style="list-style-type: none">1. Improve operational performance: Achieve Faster Diagnosis Standard performance of 77%* and 62-day referral to treatment standard of 70% by March 20252. Ensure cancer operational performance is assessed and monitored consistently and is prioritised by ICBs and Alliances during 2024/25.3. Reduce variation in Cancer Wait Times (CWT) performance and ensure performance outliers are reviewed, themes understood and escalated through Alliance governance and ICB/regional routes as required.4. Run specific projects addressing; i) mitigating known seasonal challenges; ii) rolling out the MDT streamlining guidance; iii) safety netting for abnormal radiology and pathology; and iv) treatment waiting times for radiotherapy.
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Narrative quarterly updates – word limit of 200 words *(For crossing-cutting updates, please include detail on direct support provided to the most challenged providers in Tiers 1 and 2 and provide updates on your wider plans to improve CWT performance and reduce variation, e.g. consistent Access and IPT policy. If you wish to share your audits, please upload them to your Alliance quarterly report folder. There is a word limit of 200 words per row to ensure focused updates and please do not include any graphs. Please complete the relevant section in Part 2 to report on spend and impact of activities for providers in tiering.)*

Q1	Cross-cutting	<p>FDS performance for April 74.78% and May 77.20. The deterioration in April was anticipated given the impact of Easter and IA. Both months were above our NHS GM (ICB) planning trajectory. June is currently forecast at 77%.</p> <p>62 day performance for April 68.31% and May 66.12%. May was below our NHS GM trajectory. June is currently forecasted at 65%. This is below the trajectory, largely related to MFT who are being supported to recover.</p>
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	<p>MFT is the only tiered organisation. Funding for activity to recover the breast and lung surgical backlog, and additional triple assessment capacity is agreed. A delivery plan is expected imminently. Support for the skin pathway in another provider is agreed to try and avoid tiering. A plan is expected, delivery activity from August onwards.</p> <p>Surgical deep dives have been completed in each Trust. Findings and recommendations to be delivered in Q2.</p> <p>Performance improvement meetings undertaken with each Trust. Individual action plans in place with all Trusts and will be assessed and rated Q2. Review meetings planned.</p> <p>Action plans in place for systemwide focus on three initiatives – front end pathway, single queue expansion and optimisation, surgical pathway improvement.</p> <p>Recruitment to project posts to aid delivery were unsuccessful. Currently in the process of re-advertising.</p>
Mitigating known seasonal challenges	<p>Seasonal variation in skin referrals is well known. Tele-dermatology live ahead of the summer referral peak is a key action which has been delivered to mitigate the impact. Additionally, Trusts have agreed actions to help mitigate – extra capacity, conversion from routine and follow up where clinically safe to do so. There are some aspects that cannot be mitigated due to workforce limitations.</p> <p>Bank holidays – plans are automatically generated as standard practice in GM for MDTs, clinics and activities which will be impacted. Where explicit plans are not noted in Trust improvement plans, providers have been asked to include these in their next revisions.</p> <p>Summer annual leave is a challenge we are unable to mitigate. We will continue to work with providers to monitor. Median waits and turnaround times for diagnostics are in place to support oversight and corrective actions.</p>
Rolling out MDT streamlining guidance	<p>A project manager is recruited until March 25 to support delivery of MDT reform across GM.</p> <p>A comprehensive baseline audit of MDT streamlining was conducted in Q1 across the tumour group specific MDTs in Greater Manchester. Pockets of existing good practice have been identified and learning taken into the reform work plan.</p>

	<p>The pathways where MDT reform is expected to have the greatest impact are identified as Oesophagogastric, Colorectal, Skin and Sarcoma. Working with our well established Clinical Pathway Boards, these four areas will be given priority support in the first instance.</p> <p>Oesophagogastric work is the most progressed, following three systemwide workshops to re-design the MDT to optimise effectiveness and use of clinical time. We are linking this to our diagnostic bundle work as part of FDS and operational performance, and our treatment variation actions to deliver a re-designed pathway for Greater Manchester.</p> <p>The GM Colorectal MDT have attended their first MDT Reform workshop and have agreed to work on standardising process across GM as a starting point. The initial Sarcoma MDT Reform workshop is planned for July 22nd and the Specialist Skin MDT will host their first workshop in September.</p>
Safety netting for abnormal radiology and pathology	<p>Each Trust has well-established processes in place for abnormal results via pathology, with reports cross referenced against their cancer registry systems. Not every Trust had these processes in formal documentation. Relevant Trust have an action to document these processes and to take these through their own Cancer Boards where not in place already. The Cancer Alliance will collate copies of these to ensure these are in place.</p> <p>Procedures for radiology vary. There are processes in place to upgrade patients and add them to MDT; generic emails are in place in each organisation to avoid reliance on individuals in teams. Not all processes are formally documented, and each Trust has been asked to formalise arrangements and take through their cancer boards. It is accepted that radiology holds a greater risk than pathology. A pathology report can be cross referenced, but there is no robust way to monitor the unknown element in real time – i.e. if a radiologist fails to upgrade.</p> <p>Incident reporting is in place in all organisations and themes and issues are reviewed as standard.</p>
Treatment waiting times for radiotherapy	<p>The three Cancer Alliances across the Northwest have collaborated with the Radiotherapy network to recruit an improvement manager who will work across the Northwest. Whilst there is work to be done locally, the combined role sitting with the network allows greater opportunities to learn, and share breast practice, and where action is required in multiple providers, this can be done with consistency.</p> <p>The post holder is due to commence in post July 24 and an initial meeting is scheduled with all three alliances to agree KPIs and reporting. Collectively we are working with the ODN to produce an addendum to their workplan with actions to improve radiotherapy treatment waiting times.</p>

		<p>Some pathway specific work has commenced already in GM. A pilot in H&N will commence August 24 which will look to reduce the wait from outpatient / consent to planning by 7-10 days. The pilot is planned for 3 months. For lung, a treatment subgroup is established. The first deep dive into wait times for appointments, planning and treatment is due to be presented July 24.</p> <p>The Christie (sole provider in GM) have already begun two further actions; to improve oversight / monitoring of the time to treatment date to ensure early intervention and escalation and a plan to increase capacity by reducing treatment length for multiple met SRS patients, using the new Linac. Date for capacity release is not yet confirmed. Both will be monitored through the action plan / scheduled operational improvement meetings /process in place.</p>
Q2	Cross-cutting	<p>FDS performance for June 77.20% and July 77.23%. It should be noted both months are above the GM trajectory. August is expected to be 74.19% which is just under the trajectory, and is linked solely to NCA and an issue in the skin pathway. Recovery plans are in place and have commenced.</p> <p>62 day performance for June 67.57% and July 69.69%. Although June is just below the GM trajectory, for July - it should be noted the NCA have made an incorrect submission, and the true figure should have taken the GM position to 69.52% which would have been the first month the trajectory had been achieved. This will be seen when the bi-annual update is complete in December. August performance is 70% which is above trajectory and the first time to be achieved since April 2022. All Trusts exceeded their planning trajectory, with the exception of MFT who are below both their main planning trajectory, and their recovery trajectory with a deteriorating position forecast for August. There is significant ongoing work with the Trust to recover the position.</p> <p>MFT is the only tiered organisation currently. Funding for activity to recover the breast and lung surgical backlog, and additional triple assessment capacity is agreed. A delivery plan is in place and funding will be transacted in October as activity is delivered. NCA is not currently tiered, but given the challenges and deteriorating position, additional investment has been agreed, along with significant time investment from the Cancer Alliance to recover the FDS position and prevent the 62 day performance deteriorating at a similar rate.</p> <p>Following surgical deep dives in each Trust, findings and recommendations are agreed through the GM executive medical directors and the GM Cancer Board, and implementation will continue to be worked through in Q3 and Q4.</p>

		<p>Performance improvement meetings undertaken with each Trust. Individual action plans in place with all Trusts assessed and rated. Review meetings planned for Q3, with updated action plans requested to facilitate these commencing early November.</p> <p>Action plans continue to be monitored for systemwide focus on three initiatives – front end pathway, single queue expansion and optimisation, surgical pathway improvement.</p> <p>Recruitment to project posts to aid delivery were successful as previously noted – start dates were expected at the start of Q4, however, one of these posts will now commence Q3.</p> <p>Colorectal a focus due to high numbers of patients:</p> <ul style="list-style-type: none"> - CTC waiting times continue to improve, with best performance to date in September 2024 of 42% of patients scanned and reported within 10 days (compared to 12% at the start of last year). Improvements are still in progress, and a standardised request form is in the process of being implemented across GM (currently live for one service). - Review of GM FIT negative pathway took place in September 2024, with a view to ratifying a revised document in the coming months. This document will inform the review and refresh of GM Colonic Imaging Guidelines, which is currently in progress. - Launched the SQD Subgroup for Complex Polypectomy and TAMIS/TEMS, which will put all L3/L4 colonic polyps and all complex rectal polyps into a GM-wide single queue. Clinical standardisation of complex polypectomy and TAMIS/TEMS is almost complete, to underpin this work. <p>SACT capacity & demand:</p> <ul style="list-style-type: none"> - Scoped possible approaches to SACT C&D, including model provided by MSD. Decision made to produce a local model that captures variation over time, with the Alliance agreeing to fund a BI analyst role to support this work. Recruitment is expected to commence shortly. In parallel, information will be leveraged from recently developed activity v. capacity dashboards at the tertiary provider. Dashboards have now been through local governance and the results will now be analysed.
	Mitigating known seasonal challenges	<p>Focussed work has been undertaken to secure funding for Skin Analytics, as a way of supporting the management of skin and addressing the seasonal challenges. Demand remains high, but contracting is now being progressed, with a second image read for the 'low risk' images, given the current lack of NICE approval.</p>

		Focussed work will commence to minimise the impact of the festive season, with support to make decisions outside of MDT when needed.
	Rolling out MDT streamlining guidance	<p>Baseline Audit: The Q1 baseline MDT streamlining audit results have been reviewed and shared with the tumour specific MDT clinical leads. The MDT Reform project team has shared examples of ongoing work and will support implementation of identified improvements with the MDT leads.</p> <p>Priority Tumour MDT Progress: The key tumour sites identified as priorities - Oesophagogastric (OG), Colorectal, Specialist Skin, and Sarcoma are advancing in standardising practice across GM by focusing on:</p> <ul style="list-style-type: none"> • MDT referral proforma review • Diagnostic bundles/Standards of care • MDT outcome templates <p>The Oesophagogastric (OG) reform is the most advanced, having developed diagnostic bundles and updated the MDT Referral Proforma which will hopefully be ratified at the October Pathway Board Meeting for implementation by November/December 2024.</p> <p>The Colorectal team recently attended their first MDT Reform workshop and will begin by developing diagnostic bundles and updating the MDT Referral Proforma to share at their next workshop in January 2025.</p> <p>Due to summer leave, there has been a delay in the Sarcoma and Specialist Skin MDT Reform workshops, now rescheduled for October and November (Q3).</p> <p>GM Cancer Alliance MDT Directory: Early planning to develop an MDT Directory has begun, to include timetable for MDT meetings, MDT co-ordinator contact details, links to MDT referral proforma and developed diagnostic bundles.</p> <p>NHS England MDT Improvement Programme: Two clinicians (Lung and Colorectal) are presenting their MDT Reform work at the MDT Improvement Programme learning sessions.</p>
	Safety netting for abnormal radiology and pathology	Each Trust has well-established processes in place for abnormal results via pathology, with reports cross referenced against their cancer registry systems. Not every Trust had these processes in formal

		<p>documentation. Relevant Trust have an action to document these processes and to take these through their own Cancer Boards were not in place already. The Cancer Alliance will collate copies of these to ensure these are in place.</p> <p>Procedures for radiology vary. There are processes in place to upgrade patients and add them to MDT; generic emails are in place in each organisation to avoid reliance on individuals in teams. Not all processes are formally documented, and each Trust has been asked to formalise arrangements and take through their cancer boards. It is accepted that radiology holds a greater risk than pathology. A pathology report can be cross referenced, but there is no robust way to monitor the unknown element in real time – i.e. if a radiologist fails to upgrade.</p> <p>Incident reporting is in place in all organisations and themes and issues are reviewed as standard.</p>
	Treatment waiting times for radiotherapy	<p>The three NW alliances continue to collaborate. Project manager recruited via radiotherapy network and commenced in post end July 24. Data review completed, priorities and workplan agreed and work commenced with all three sites.</p> <p>Locally, a pilot is in place in H&N where initial results suggest around a 9 day improvements in patients commencing their radiotherapy. It is anticipated that a full review will take place in December, but that this pilot will be moved to BAU. Learning will be taken into other tumour sites within GM and shared across the NW.</p>
Q3	Cross-cutting	<p>FDS performance for October was 76.86% and November 79.05%. It should be noted both months are above the GM trajectory, with November exceeding the end of March ambition of 77%. December is forecasted to be around 79% and GM is on track to deliver the March target of 77%.</p> <p>62 day performance for October 69.72% and November 71.11% with all providers except MFT delivering their individual planning trajectory. December performance is currently forecast to be slightly less than this, given the disruption to performance over the festive period. MFT remains significantly challenged in delivery. All Trusts with the exception of MFT have recommitted to the delivery of the end of March target of 70%. It is hoped that over performance in other Trusts will deliver the 70% standard for GM overall. Significant work is being undertaken to support MFT.</p> <p>Colorectal continues to be a focus, due to high patient volumes and FDS performance below 77%. FDS performance improved from 63.4% (May) to 69.4% (November).</p> <ul style="list-style-type: none"> Standardised CTC request form now live across NCA and expected to be live at WWL, MFT in early Q4.

		<ul style="list-style-type: none"> • Pilot work has commenced at MFT to explore the feasibility of a patient-level GM endoscopy dataset. • Work continues towards a GM single queue for L3/4 complex polypectomy. Clinical standardisation has been completed, and a clinical standardisation review meeting was held to ensure that there is a consistent approach to polypectomy across GM. SQD for TAMIS/TEMS has been put on hold due to clinical concerns around the repeated number of patient visits that would be required to the providing site for a surgical procedure. • GM FIT negative pathway has been refreshed and ratified. • GM SOP for communication of cancer post endoscopy has been developed and ratified. <p>SACT capacity and demand</p> <ul style="list-style-type: none"> • Review of activity vs capacity over the past 18 months for SACT delivered at Christie main site is now completed and has been presented to the SACT Board. Further work is planned to expand the analysis. • Development of a full capacity and demand model will commence in Q4.
	Mitigating known seasonal challenges	<ul style="list-style-type: none"> • Review of 62-day performance for colorectal identified seasonal challenges in Jan, April and September. Highlighted to colorectal pathway board January 2025. • Continued mobilisation of Skin Analytics, as a way of supporting the management of skin and addressing the seasonal challenges. In Q3 3 sites now live.
	Rolling out MDT streamlining guidance	<p>Priority Tumour MDT Progress: The key tumour sites identified as priorities - Oesophagogastric (OG), Colorectal, Specialist Skin, and Sarcoma are advancing in standardising practice across GM by focusing on:</p> <ul style="list-style-type: none"> • MDT referral proforma review • Diagnostic bundles/Standards of care <p>The Oesophagogastric (OG) MDT have developed diagnostic bundles which were ratified at the October Pathway Board Meeting. Following this, Standards of Care pathways are now being created for the group cohorts identified within these diagnostic bundles. Additionally, the order of discussion at the MDT meetings has been reviewed and adjusted to streamline processes, considering the average number of patients listed at each hospital. An MDT recommendations document is currently in the process of being developed to ensure that all trusts are standardising practice across GM.</p>

	<p>The Colorectal MDT has reviewed and updated their MDT referral proforma and made progress in drafting diagnostic bundles. Both will be presented at the next workshop in February for feedback. Additionally, an audit has been conducted across all trusts hosting a colorectal MDT in Greater Manchester to identify which trusts have implemented an electronic MDT proforma and MDT triage.</p> <p>The Specialist Skin MDT have implemented quality control check at MDT to ratify the MDT minutes, with the MDT lead supporting the MDT co-ordinator in summarising the MDT outcome. Progress is being made in updating the MDT referral proforma, and a Task and Finish group has been established to develop a standard letter for referrers who submit an incomplete MDT referral proforma.</p> <p>The Sarcoma MDT has reviewed their radiology reporting process to ensure that USC radiology reporting is not outsourced. Progress is being made in updating the MDT Referral proforma. The GP referral has been updated and implemented.</p> <p>GM Cancer Alliance MDT Directory: Information has been collated for the MDT Directory, which includes a timetable for MDT meetings, cut-off times for MDT listings, and contact details for MDT coordinators. We aim to add additional MDT documents, such as referral proformas, diagnostic bundles, and Standards of Care pathways. A discussion is pending on where this information should be housed, given concerns about public and patient access to the GM Cancer Alliance webpage.</p> <p>GM MDT Reform Education Event: Scheduled for March 11th. This event will be focused on educating MDT teams on the work completed to date within the MDT Reform Project to try to encourage further uptake and compliance.</p>
Safety netting for abnormal radiology and pathology	Work continues to ensure each Trust has documented processes for abnormal results that have been ratified at their Cancer Board meeting. At present this is incomplete in 3 sites
Treatment waiting times for radiotherapy	<p>Greater Manchester, Lancashire and South Cumbria and Cheshire and Merseyside Cancer Alliances have sought the support of the Radiotherapy ODN to bring together the three radiotherapy providers in the North West to identify and develop a workplan for improving radiotherapy waits and consequently, 62-day performance against CWT. Planning has been undertaken with the support of a dedicated project manager, funded by the alliances jointly, to map and standardise 4 priority tumour sites (Head and Neck, Prostate, Gynaecological, and Lung). Improvement projects across the network will commence implementation from Q4 onwards.</p> <p>In GM the H&N pilot has concluded, with improvement of approximately 5 pathway days saved on average comparing October when the pilot started to December. This has resulted in eliminating the radiotherapy treatment 62 day breaches from a treating trust perspective (in time if IPT day 38 or earlier or re-allocated</p>

		in full, thus further encouraging improvement in the diagnostic phase as a result. Given the success this is now transitioning to business as usual, and the Cancer Alliance are supporting work on expanding the same principles and work across other pathways.
Q4	Cross-cutting	
	Mitigating known seasonal challenges	
	Rolling out MDT streamlining guidance	
	Safety netting for abnormal radiology and pathology	
	Treatment waiting times for radiotherapy	

Updates against quarterly milestones *(Use this space to confirm if progress is in line with milestones set in the 24/25 Alliance plan, and if/why any need to change.)*

Q1	<p>Review of dashboard, and data used with the ICB and throughout GM complete. Heat maps in place at provider and pathway level. Wider ‘underpinning metrics’ data dashboard commissioned and due for release July 24.</p> <p>Systemwide project plans for three overarching projects completed and in place. Histopathology project has not commenced, and will be a priority in Q2.</p> <p>Radiotherapy project commenced with actions both regionally with the Radiotherapy network and with the GM provider and associated clinical pathway board.</p> <p>Recruitment for key additional project posts has been unsuccessful for all but 2 posts. 1 new staff member in place, but this replaces an employee who left the organisation. A project support officer is appointed and is expected to commence work September 24. Posts are in the process of being re-advertised.</p> <p>Key system projects are established</p> <p>Collated all safety netting procedures and gap analysis and actions in place</p> <p>The second in a series of MDT meetings with OG has taken place and the first in Colorectal is now scheduled for July instead of June due to workforce availability.</p> <p>Actions to mitigate / reduce seasonal impact in place across all providers</p> <p>Additional PWB agreed projects are reliant on recruitment. Planning has commenced, but projects will not launch fully until recruitment is complete.</p> <p>NSS funding has now been secured for 24/25 through NHS GM, with the Cancer Alliance contributing £460,000. 25/26 onwards will form part of the normal planning round for providers.</p>
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Q2	<p>In addition to the previous dashboards and heat maps, the Cancer Alliance have created scorecards of ‘underpinning’ metrics; IPT compliance, FDS by cancer confirmed, single site 62 day compliance, PTL size, backlog, 104 day patient numbers.</p> <p>Delivery of systemwide projects continues – there is focussed work on LGI described above, there is a bladder task and finish group in place, a focus on Gynaecology through our FD delivery group, with results of an ovarian one stop pilot pending. SQD continues its expansion, with the evaluation to date completed September and approved via the GM Cancer Board. Procurement and business care for a longer term investment in the process will be a key action for Q3</p> <p>A workplan review has taken place, with greater emphasis placed on the two largest Trusts in GM where performance remains more challenged.</p> <p>H&N Improvement Facilitator post remains unfilled, and is currently out to advert</p> <p>The one stop OG clinic was expected to go-live. Issues with estate in the host organisation have delayed the launch. The Cancer Alliance is supporting resolution with the provider (NCA).</p>
Q3	<p>Pathway improvement work continues with the delivery group becoming a pivotal forum for sharing good practice, addressing challenges and discussing improvement work. The ovarian pilot results (below) have now been shared with the Clinical Pathway Board to gain support for roll out. SQD continues to develop, with an expansion strategy in an outline position. Good progress has been made with complex polypectomy, EUS and HPB. Work continues to help gain traction in PET and LATP increased clinical leadership is in place to support and is planned to be formalised in Q4. Work has commenced to implement a Small Cell expedited pathway, a project is under way about advanced practice in breast radiology with deep dives being under taken in Trusts. In depth breach analysis is under way in key pathways to continue focus on identifying areas for improvement. The OG one stop service, as part of the CTOC work programme (Cancer Treatment and Optimisation Clinic) is progressing, with estate issues now resolved with plans for launch well underway and operational group meetings in place. Go live is now planned for the end of Q4 (given recruitment requirements).</p> <p>Bladder task and finish group work continues, with a proposal on an expedited pathway for muscle invasive tumours being progressed via the PWB. CTOC is being explored within HPB, Bladder, Prostate with a view of replicating the benefits seen in lung. An oversight group and project management structure is in place to drive the pace of this work, which bridges across operational performance and treatment variation.</p>
Q4	

Risks *(Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)*

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter)				

- 1) Ability to secure the necessary additionality required in diagnostic capacity / reporting and theatre capacity due to conflicting priorities, workforce constraints, financial constraints and HR policy (head count). Q4 is expected to be even more challenged given the GM additional rate payment work which is reducing staff willingness to undertake additionality.
- 2) Opportunities to increase capacity that require associated capital cannot be progressed due to capital allocations across GM being over-committed and high demand on capital from a patient safety perspective

Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter)

- 1) System-wide plan, supported at Chief Exec level across each provider organisation and with ICB support. In/outsourcing, LLP, transformation plans for pathways. Robust monitoring
- 2) Unable to mitigate as the cancer alliance does not have a capital allocation.

2.2 Faster Diagnosis Priority Pathways – Skin

Deliverable	<ul style="list-style-type: none"> Lead a project with primary and secondary care partners to complete the roll out of Tele dermatology where this is still outstanding, across all USC skin pathway providers by June 2024, with services commissioned as BAU by March 2025. Work with providers in tiering where USC skin pathways have been identified as a priority pathway and those with lower than 85% FDS performance on the USC skin pathway to complete a baseline pathway analyser of 30 patients, investigate and identify challenges, agree recommendations and next steps for improvement. Priority should be given to tier 1 providers in Q1, with other tiered providers prioritised for action by end Q2. Support and hold providers to account for delivery of improvement plans, including repeating pathway analysis at 6 months to evaluate impact of action/ recovery plan.
Success measures	<ul style="list-style-type: none"> % of urgent suspected cancer referrals for skin meeting FDS % of USC referrals managed through Tele dermatology Improvement against plan demonstrated by submission of baseline and repeat pathway analyser tool

Narrative quarterly updates *(Please include detail on transition of implemented telederm services into business as usual and further roll out of telederm in named primary care/ providers. Provide information on pathway analyser work completed, detailing which providers, any key challenges identified, and status of improvement plans/ actions taken. Provide detail of other pathway improvement work undertaken outside of telederm pathways or pathway analyser work.)*

Q1	<p>FDS April 87.11% and May 87.11% for skin, with all trusts individually above 83% in both months. Pathway Analyser completed for priority providers (as detailed in planning guidance) and commenced for 2nd phase. Phase 1 AI funded pilots (2 in total) commenced in May'24 and so this has impacted the overall >50% SCR submission; this is expected to improve as capacity is expanded. Phase 2 AI funded pilots moved into mobilisation phase. Across GM tele dermatology is live in one form or another across all providers.</p> <p>MFT are piloting a one stop tele dermatology model, where the patient attends for image capture, AI result and excision in the same attendance. Monitoring of this pilot and learning will be shared.</p> <p>There is some widespread clinical concern regarding the skin analytics platform and the 'no second / human read'. This is multifaceted, with concern over missed diagnosis previously reported through national forums, the lack of a defined diagnosis to patients / Primary Care such as 'expected to be non-cancer' but not informing of BCC, Seb k etc. Some Trusts are currently unwilling to remove a second read, thus not realising the full benefits currently. All issues have been fed into the national tele dermatology forums. It is expected that an announcement by NICE approving the use of the AI report without second read will provide much needed reassurance. GM have requested an update from the national team on the likely timescale for this but have not had confirmation at the time of writing.</p>
Q2	<p>Pathway Analyser data received for phase 2 sites; reports being finalised with providers.</p> <p>NICE draft public consultation issued in September'24 which does not support autonomous tele dermatology. Edge Report issued at a similar time was more favourable. To address clinical concerns across GM and encourage mobilisation of NHSE Phase 2 funding, GM has agreed a safety net around the low risk cases identified through DERM.</p>
Q3	<p>The latest skin performance in GM is 84.07% FDS. The most challenged provider has been NCA, causing them to enter the tiering process. FDS is now recovered overall, with NCA Skin FDS at 78.81%. All pathway analysers completed for all GM providers of dermatology services.</p> <p>Second read safety net in place for all providers whose NHSE AI funding did not include this element (see Q2 narrative); 3 providers now live with the implementation of AI with 2 more going live at the start of Q4 (Jan'25).</p> <p>Interestingly GM has a primary care Skin Analytics pilot which commenced in Nov'24 – close monitoring of activity and potential impact on secondary care referrals underway.</p> <p>Dashboard developed to understand activity through AI which will support a wider evaluation.</p> <p>62 day performance for skin is at 76.61% (November 24).</p>
Q4	

Updates against quarterly milestones *(Use this space to confirm if progress is in line with milestones set in the 24/25 Alliance plan, and if/why any need to change.)*

Q1	<p>Progress is in line with all milestones (roll out of tele dermatology and pathway analyser). The pathway analyser completed in NCA reinforced the key issues known, primarily they relate to a capacity and demand mis-match across the entire pathway. MFT largely surrounding capacity / histopathology.</p> <p>Work with GM Cancer Alliance BI team to establish a report for SCR managed through tele-dermatology now established and live on curator; this will support discussions with providers to ensure first appointment via tele dermatology is captured as 'image clinic'. Optimisation of AI and the new services is now a key focus.</p>
Q2	Progress is in line with all milestones (roll out of tele dermatology and pathway analyser).
Q3	<p>Progress is in line with all milestones (roll out of tele dermatology and pathway analyser).</p> <p>>50% SCR managed through telederm: making progress with November (38.5%) up on October (30%) and September (29.4%) – however the range across GM various from 9% to 68%</p>
Q4	

Risks (Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
<p>Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter)</p> <ol style="list-style-type: none"> 1) Tameside have been closed to new referrals (due to workforce fragility) since October 23. Although the site is now taking some activity back via NCA this is currently 40 referrals per week suitable for tele dermatology, leaving a residual risk of c40 patients per week at NCA, which are not suitable for tele-dermatology, requiring face to face capacity 2) Demand is significantly higher than plan. 3) There is system fragility with the wider dermatology services (including cancer) under the sustainable services framework. Some providers cannot deliver their core capacity without reliance on insourcing / outsourcing / LLP which in some areas lacks reliability and consistency 4) Clinical concern over the use of Skin Analytics, given the NICE appraisal statement 5) Risk to continued use of Skin Analytics in GM due to second read requirements currently, and insufficient direction and support whilst NICE review continues 				
<p>Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter)</p>				

- 1) Continued work with Tameside to support the re-opening of further capacity; this needs to be managed in line with infrastructure and capacity without destabilising team but is necessary to support NCA. At risk additional insourcing is currently being delivered at NCA
- 2) On going GP education, feedback on referrals, trusts asked to consider urgent non-cancer capacity to provide primary care with another option other than first appointments at c40 weeks. Mitigation is hoped to reduce risk but not eliminate.
- 3) Systemwide dermatology transformation programme in place (ICB lead). Unable to mitigate currently
- 4) Second read agreed and in place to support clinical concerns with audit planned on any patients retained following the second read of 'low risk' images.; review Feb'25.
- 5) Conversation with Skin Analytics to understand how contracts can be aligned to a similar end date whilst GM undertakes a full evaluation to consider future telederm models,
- 6) Proposal taken to Programme Board on 'first call' of SDF for 25/26 to support extension of Skin Analytics in 2 sites who's contracts expire May 25 to October 25 in the hope a national decision on the future use of skin analytics is in place by then. Significant risk to Q3 and Q4 25/26 as skin analytics does not currently reflect ROI without autonomous read, risking the GM financial position or removal of the product in Q3.

2.3 Faster Diagnosis Priority Pathways – Gynaecology

Deliverable	<ul style="list-style-type: none"> Lead a project with primary and secondary care partners to design and implement an unexpected bleeding pathway for people receiving HRT to reduce unnecessary referrals and enable management outside an urgent suspected cancer referral where clinically appropriate. Alliances to have mobilisation plan and commenced pilot/ implementation/ roll out by end Q2, aiming to cover 50% of applicable services by Q3 and 100% of applicable services by Q4. Work with providers in tiering where gynae has been identified as a priority pathway and those with lower than 60% FDS performance on the USC gynae pathway to complete a baseline pathway analyser of 30 patients, investigate and identify challenges, agree recommendations and next steps for improvement. Priority should be given to tier 1 providers in Q1, with other tiered providers prioritised for action by end Q2. Support and hold providers to account for delivery of improvement plans, including repeating pathway analysis at 6 months to evaluate impact of action/recovery plan.
Success measures	<ul style="list-style-type: none"> % of urgent suspected cancer referrals for gynaecology meeting FDS Increase in number and proportion of FDS clock stops recorded as 'diagnosis of cancer' Number of patients referred onto an alternative unexpected bleeding pathway Improvement against plan demonstrated by submission of baseline and repeat pathway analyser tool

Narrative quarterly updates *(Please include detail on rollout of plans at provider/ primary care level for unscheduled bleeding pathways. Include any information on proposals to utilise CDCs/ women's health hubs. Provide information on pathway analyser work completed, detailing which providers, any key*

challenges identified, and status of improvement plans/ actions taken. Provide detail of other pathway improvement work undertaken outside of unscheduled bleeding or pathway analyser work.)

Q1	<p>FDS April 68.63% FDS May 67.04%. FDS by confirmed cancer cohort April 40.43% May 39.53%. Two organisations have fallen below 60% overall in May, and will complete pathway analysers in Q2.</p> <p>Gynaecology, particularly the endometrial pathway remains a key challenge for cancer in greater Manchester, and more widely across elective care and long waiting patients (65 weeks +).</p> <p>Systemwide transformation is underway for gynaecology service delivery across Greater Manchester. The Cancer Alliance participated in a gynaecology 'think tank' in June where new service models are being considered. There are significant demand pressures across all referral priorities, with elective waits extensive. There is also pressure from maternity / obstetrics which are combined roles in many organisations. A tier two model is currently being considered.</p> <p>A gynaecology clinical reference group which is led by a nominated Executive Medical Director is in place along with the Cancer Clinical Pathway Board, with system wide representation for all aspects of the pathway.</p>
Q2	FDS performance for August 24 is 65.45%. There has been significant issues in two organisation, both of which are resolved and performance beginning to improve. HRT pathway in place throughout GM and will be monitored for impact. Further actions are being reviewed in line with the output of the ovarian one stop and non-clinical triage work being undertaken at one trust.
Q3	FDS performance for October is 70.34% (increased from 65.80% in Sept).
Q4	

Updates against quarterly milestones (Use this space to confirm if progress is in line with milestones set in the 24/25 Alliance plan, and if/why any need to change.)

Q1	<p>The Clinical Pathway Board has undertaken a review of the primary care PMB on HRT pathway, and the existing PMB algorithm for GPs has been updated to incorporate British Menopause Society updated HRT guidelines.</p> <p>The updated pathway is supported by the updated GP Clinical Decision Support tool (linked to EMIS).</p> <p>A programme of educational updates for GPs has been agreed with the algorithm being presented to the local PCN leads in June. Audit on effectiveness was not completed in Q1, as it was felt to be more appropriate after the updated pathway and after the education programme had commenced.</p> <p>Evaluation of non-clinical triage model in place ongoing, a decision on further pilot will be determined once complete.</p>
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	<p>Pathway Analyser work commenced in tiered provider (although their FDS for gynaecology was not below 60%). Priority has been given to other tumour sites but is planned for completion in August.</p> <p>Data in place to monitor milestone waits in each pathway – used routinely by trusts to support action planning and improvement.</p> <p>OP to IP hysteroscopy conversion review is yet to be completed, however, instead there has been concentration on proactive work on procedure communication to patients, which was identified as an opportunity to drive improvement.</p>
Q2	<p>FDS July 65.45% (increased from 64.73% in June).</p> <p>The GP clinical decision support tool on EMIS which supports the unscheduled bleeding on HRT pathway was rolled out in September. There had already been GP education session around this. The Alliance Primary Care PCN facilitators will support GPs with this and referrals into secondary care will be monitored from Q3.</p> <p>GM Cancer Alliance participates in the NHSE pathway improvement group. NHSE recommended hysteroscopy guidance shared with all Trusts. Gynae improvements discussed with all Trusts at GM Faster Diagnosis Delivery group and with Alliance funded trust improvement managers forum – support offered.</p> <p>Pilot of ovarian straight to test pathway undertaken within one trust – results and recommendations to be shared.</p> <p>Alliance project manager supporting one of lowest performing trusts with their gynae improvement group. First mapping session in Q3.</p> <p>A group to look at standardising patient information for hysteroscopy has been established and guidance written. To undergo sign off in Q3.</p> <p>OP to IP hysteroscopy conversion being undertaken as part of a wider clinical audit.</p> <p>Bids in with NHSE for support with gynae pathways in CDCs in Oldham and Bolton</p> <p>Pathway analyser being completed for lowest performing trust.</p>
Q3	<p>FDS October 70.34% (increased from 65.80% in Sept).</p> <p>Unscheduled bleeding on HRT algorithm live in GP systems. Referrals into secondary care remain steady - no reduction seen at present but not increasing.</p> <p>Ovarian straight to test pilot information shared and being considered in other GM trusts. Pilot outcomes to be presented to clinical colleagues at Pathway Board in Jan 2025. Pilot results included: 25% shift in FDS Performance for Ovarian GP referrals</p>

	<p>21% shift in Cancer Confirmed FDS Performance for Ovarian GP referrals. Year to date FDS average days to communicate (referrals received post pilot) 16.92</p> <p>All trusts currently have consultant or CNS triage in place, navigator support being considered in Bolton.</p> <p>Patient information leaflet for hysteroscopy written – this now needs to be processed through Easyread, sharing with small communities, and taking back through the T&F group before implementation in Q4.</p> <p>CDC bid successful in Bolton and 5 sessions per week to support the gynae pathway will commence in Jan 2025.</p> <p>OP to IP hysteroscopy conversion work continues. NCA focus on bringing down wait to GA to within 7 days.</p>
Q4	

Risks (Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) 1) Conflicting pressures and priorities – elective long waits, maternity and cancer 2) Demand – in particular for the endometrial pathway. Inability to convert capacity from routine to cancer. HRT pathway is also designed to support demand management, but this is not yet seen in referrals (too early to determine)				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) 1) Collaborative work between all work programmes. In sourced capacity in place 2) Ongoing GP education, PMB HRT pathway, insourced additional capacity.				

2.4 Faster Diagnosis Priority Pathways – Urology

Deliverable	<ul style="list-style-type: none"> Lead a project with secondary care partners to implement risk stratification tools, such as Predict/ Cambridge Prognostic Groups, to reduce unnecessary progression to biopsy and/or progression to treatment regimens. Complete the implementation of nurse-led LATP biopsy services in providers delivering prostate pathways. Work with providers in tiering where Urology has been identified as a priority pathway and those with lower than 60% FDS performance on the USC Urology/prostate pathway to complete a baseline pathway analyser of 30 patients, investigate and identify challenges, agree recommendations and next steps for improvement. This should include a focus on the wider Urology pathway beyond Prostate cancer, with a particular focus on bladder cancer pathways where there are significant and growing challenges. Priority should be given to tier 1 providers in Q1, with other tiered providers prioritised for action by end Q2. Support and hold providers to account for delivery of improvement plans, including repeating pathway analysis at 6 months post baseline to evaluate impact of action/ recovery plan.
Success measures	<ul style="list-style-type: none"> % of urgent suspected cancer referrals for urology meeting FDS Increase in number and proportion of FDS clock stops recorded as 'diagnosis of cancer' Improvement against plan demonstrated by submission of baseline and repeat pathway analyser tool.

Narrative quarterly updates (*Please confirm status of audit of non-medically delivered LATP including identified next steps and details of any actions taken regarding MRI capacity. Please provide information on pathway analyser work completed, detailing which providers, any key challenges identified, and status of improvement plans/ actions taken. Provide detail of other pathway improvement work undertaken for bladder pathway.*)

Q1	<p>FDS April 58.36% FDS May 61.78%. There is variation within provider organisations, and based on the May data, three organisational will be asked to complete pathway analysers. FDS for the cancer confirmed cohort April 23.92% May 37.74%.</p> <p>Significant work has been undertaken across the urology pathway. A prostate workshop was undertaken previously, and work on actions has continued, included focussed work on triage processes. A clinical lead is appointed, and a working group established for the LATP single queue. Capacity and demand modelling will also be undertaken as part of this work.</p> <p>Two sites have now agreed to pilot a new 'single visit' MRi, hot reported and biopsy on the same day (where needed).</p> <p>LATP and MP MRi reporting remain the key challenges in the prostate pathway. GM continues to develop nurse led LAPT services, although access to external training has been limited in place numbers available, and one cohort / intake was cancelled by the</p>
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	<p>education provider. The Cancer Alliance is supporting backfill for on-site clinical supervision where this is a barrier. An AI pilot for MP MRi reporting is also currently being scoped.</p> <p>A bladder workshop was delivered in Q1, with a working group established across the GM system. Actions include triage, and optimisation of CT prior to first clinic attendance, with flexi on day. Waiting times for TURBT remains a challenge. Work is being undertaken, including an activity assessment. A hub model is being considered, but this data collection is being undertaken to inform this proposal.</p> <p>Each Trust has an action plan related to Urology, which is monitored.</p>
Q2	<p>FDS July 59.32% Pathway analysers completed for lowest performing trust.</p> <p>Bladder Task & Finish group is live with an action plan formulated. GM wide step down from cystoscopy policy for ratification. Significant work completed by BI team regarding TURBT activity with a view to informing the need for a hub model. Decision to be taken via task & finish group.</p> <p>Nurse led LATP services continue to be implemented with a further cohort likely to be signed off as competent in Oct 24. The Alliance workforce and education team are completing a workforce evaluation to support the roll out.</p> <p>Meetings continue to discuss LATP single queue. Likely to be piloted by one sector initially. Clinical lead appointed</p> <p>Alliance project manager supporting improvement meetings at lowest performing provider.</p>
Q3	<p>FDS October 66.67% (improved from 57.79% in Sept).</p> <p>Bladder Task & Finish group continues with a pilot in one trust to consider prioritisation of muscle invasive patients for TURBT. If this is successful, this will be rolled out mitigating the need for a GM wide hub model.</p> <p>LATP SQD meetings commenced.</p> <p>A bid for AI for prostate MRI scans is submitted</p>
Q4	

Updates against quarterly milestones *(Use this space to confirm if progress is in line with milestones set in the 24/25 Alliance plan, and if/why any need to change.)*

Q1	<p>All Trusts are using the Rotterdam risk stratification tool. This is being used in all sites as part of the shared decision making with patients regarding progress to biopsy</p> <p>The working group for LATP SQD is in place</p> <p>C&D data collection is planned but has not yet commenced. Lessons learnt from EUS C&D suggest collection of data is more effective once some of the working group actions are well progressed, and there is greater understanding about the intricacies of each service operation.</p> <p>There is continued implementation of nurse led LATP, with support provided related to clinical supervision</p> <p>Average TAT are collated for MRI scanning based on PTL. A unified coding of procedures has been agreed with the Imaging Network, and its use has been commenced. This will allow automated data extraction and robust longer term reporting.</p> <p>Work programme for Bladder T&F group agreed and actions commenced.</p> <p>Continued sourcing of additional training places for LATP and willing staff ongoing</p> <p>The Cancer Alliance have offered to lead the roll out of shared specialist reporting, as part of the Pacs Based Reporting project. It is not yet clear when this can be delivered given the current roll out plan is Trust by Trust as opposed to speciality. However, work is ongoing to embark on an AI pilot in this area.</p>
Q2	<p>Work on standardisation of risk stratification for the prostate pathway continues.</p> <p>Nurse led LATP implementation monitored & supported by Workforce & Education team.</p> <p>Bladder task & finish group has agreed action plan with data now available on TURBT activity to support decisions.</p>
Q3	<p>The Rotterdam risk stratification tool is being used in all Trusts. Whilst it is only one component of decision making, and SOP has been developed to support its use.</p> <p>Nurse led LATP implementation continues with plans to implement clinics following training being collated. Backfill offered to support mentoring following training. There are now 8 nurses who have completed their training. Two are delivering clinics, two are completing their preceptorship under supervision.</p> <p>LATP SQD subgroup established and initial meetings commenced. Currently aim is to pilot with 2 trusts only with a view to rolling out across GM if successful.</p> <p>Bladder task and finish group supporting one trust to pilot prioritisation of muscle invasive patients to TURBT. Results will be shared.</p>

Q4	

Risks (Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) 1) LATP capacity 2) Specialist MP MRi reporting capacity 3) TURBT capacity				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) 1) Continuation of nurse led service establishment. LATP shared capacity programme (SQD) 2) PACS based reporting (shared image reporting programme); outsourced routine reporting to create capacity, AI pilot 3) Bladder work programme, including scoping hub option				

2.5 Faster Diagnosis Priority Pathways – Breast

Deliverable	<ul style="list-style-type: none"> Lead a project with primary and secondary care partners to implement sustainable breast pain pathways for people to be managed outside an Urgent Suspected Cancer referral in two thirds of providers by end Q2 and all providers by end of Q4. Work with providers in tiering where USC breast pathways have been identified as a priority pathway and those with lower than 85% FDS performance on the USC breast pathway to complete a baseline pathway analyser of 30 patients, investigate and identify challenges, agree recommendations and next steps for improvement. Priority should be given to tier 1 providers in Q1, with other tiered providers prioritised for action by end Q2.
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	<ul style="list-style-type: none"> Support and hold providers to account for delivery of improvement plans, including repeating pathway analysis at 6 months to evaluate impact of action/ recovery plan.
Success measures	<ul style="list-style-type: none"> % of urgent suspected cancer referrals for urology meeting FDS Increase in number and proportion of FDS clock stops recorded as 'diagnosis of cancer' Improvement against plan demonstrated by submission of baseline and repeat pathway analyser tool.

Narrative quarterly updates *(Please include detail on rollout of plans at provider/ primary care level for breast pain pathways. Provide information on pathway analyser work completed, detailing which providers, any key challenges identified, and status of improvement plans/ actions taken. Provide detail of other pathway improvement work undertaken outside of breast pain or pathway analyser work.)*

Q1	<p>GM Cancer Alliance has well established improvement plan for Breast, which includes demand management through extensive and continued education in primary care. This has resulted in reduced referrals for Breast symptomatic, which allows the limited resource to be better utilised. Breast radiology remains a major challenge in delivering the volume of triple assessment appointments needed. A work programme on developing advanced practice and the utilisation of these roles in Breast has commenced.</p> <p>In 3 breast units, the mastalgia pathway is now business as usual. 2 units struggling with triage delivery, meetings pending to try and resolve this. 1 unit has not yet implemented its mastalgia pathway and are being supported.</p> <p>GM Cancer actively participates on the monthly NHSE Breast Pain Implementation Group.</p> <p>Current work ongoing to ensure sustainability of a quality mastalgia pathway in Greater Manchester & East Cheshire in the long term.</p>
Q2	<p>Mastalgia pathway is still outstanding in one provider. Meetings continue to try to reach a solution. Evaluation of the other pathways is in progress with the pathway board. Work on sustainability continues.</p> <p>Meetings with the AP workforce across GM Cancer continue with work on agreeing standards across the area in development.</p> <p>Breast pain pathways discussed with Manchester Women's Health Hub team, and they are linking in with the Alliance Primary Care and Workforce and Education as regards GP education.</p>
Q3	<p>FDS performance October 95.65% (improved from 94.70% in Sept).</p> <p>Mastalgia pathways now live in all trusts (last provider online in December). Work to ensure sustainability continues with providers.</p>

	Radiology AP workforce group are agreeing standards for consideration across GM. With the intention of improving skills and maximising workforce outside of medical teams
	Support given to organisations with the highest challenges
Q4	

Updates against quarterly milestones *(Use this space to confirm if progress is in line with milestones set in the 24/25 Alliance plan, and if/why any need to change.)*

Q1	<p>Work ongoing to complete full roll out of mastalgia pathway to the remaining site</p> <p>GP education on breast pain is well established and is continuing</p> <p>The second in series of four workshops for AP in radiology has been delivered and an agreed set of actions will be produced, agreed and commenced from Q2</p> <p>Recruitment to the planned part time project manager to support AP workstream was unsuccessful. The post is currently being re-advertised. As a result, the audit plan to evaluate impact of mastalgia pathway and education on breast pain (referral volumes, referral quality, volume of patients seen on mastalgia pathway, and adverse events) has not yet commenced, but will be actioned upon recruitment.</p>
Q2	<p>Work on the case for sustainability and effectiveness of existing pathways continues for mastalgia.</p> <p>AP in radiology working on producing standards for consideration across GM.</p>
Q3	<p>Final provider live with mastalgia pathway (Dec 24). Work on sustainability continues in conjunction with Breast Pathway Board, although this may not be a focus for the operational team based on proposed CWT guidance.</p> <p>Meetings with AP workforce continue with standards for GM to be written.</p>
Q4	

Risks *(Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)*

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) 1) Breast radiology workforce and inability to outsource work to generate capacity in this area 2) Capacity for mastalgia triage and GM inability to increase headcount 3) Sustainability case for mastalgia pathway in the current financial climate and given the proposed change to the CWT guidance. If breast symptomatic becomes an '18 week' pathway, sustainable investment will be more difficult				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) 1) AP work programme commenced 2) Unable to mitigate against the headcount in GM. Work continuing to support organisations to short term resolution (increased hours) 3) Unable to mitigate GM financial climate. Evidence based sustainability case will be produced.				

3 Workstream: Early Diagnosis

3.1 Targeted Lung Health Checks (TLHC)

Deliverable	<ul style="list-style-type: none"> • Invitation, Lung Health Check (LHC) attendance and CT scan run rates in line with expansion plans agreed with the national team. • 100% rollout plans, including realistic delivery trajectories, an outline of the strategic approach to core infrastructure, and a plan to meet the requirements of a national screening programme. (Overview; Template & Guidance; Modelling Tool) • Uptake of LHCs above 53% in year (representing a 5% increase nationally) and to maximise uptake of follow-up low dose CT scans for those who qualify.
Success measures	<ul style="list-style-type: none"> • Number of first invitations sent to eligible participants vs trajectory • Number of Lung Health Checks completed vs trajectory • Number of CT scans completed vs trajectory (baseline and follow-up combined) • Number of invites sent vs accepted (Uptake % of Lung Health Checks) • Number invited to 2-year scan vs accepted

Narrative quarterly updates *(Please provide updates against the Alliance 100% rollout plans (including any delays to submissions, changes to infrastructure plans etc); uptake of LHCs including any local data the Alliance would like to share and local initiatives to increase uptake throughout the year, providing detail on increasing uptake with current smokers and underserved communities; and maximising uptake of follow-up low dose CT scans for those who qualify)*

Q1	100% rollout plans	<p>The GM TLHC programme has increased LHC and CT capacity in Q1 due to the mobilisation of 2 further mobile CT scanners. There are now 4 mobile CT scanners and mobile community clinics in operation across GM. This additional capacity has enabled the expansion of the programme to new localities (sub-ICB places) across GM. The PCN rollout plan continues to progress at pace; In Q1, approx. 30 GP practices were onboarded to the programme with 30k invites sent.</p> <p>We monitor progress on a weekly basis and work closely with provider organisations to ensure commissioned capacity is utilised. There has been variance to the initial trajectories and these will be revised to reflect what can be realistically achieved for the remainder of the year. This revision in trajectories does not result in any decrease in capacity but will more accurately reflect the latest uptake figures.</p> <p>To support 100% rollout plans, NHS GM ICB commissioned additional diagnostic capacity to safely manage the increased outputs from the TLHC programme. This capacity is being mobilised although there remains workforce, estate, and capital challenges, most notably in relation to interventional radiology</p>
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	Uptake of LHCs	<p>Up until April 2024, the uptake of LHCs in GM is 49.3% although it is expected that this figure is revised upwards given the nature of the aggregate dataset.</p> <p>In some locations, we have experienced higher than anticipated DNA rates and have had to increase invitations to ensure capacity is well utilised where possible. Our providers have implemented a number of interventions to facilitate attendance such as courtesy calls, interactive text messaging, and patient questionnaires to determine eligibility. There has been a large volume of never-smokers attending the service, resulting in a loss of income and activity. This is due in part to the quality of primary care data used to invite participants to the programme. Our patient communications have been updated to simplify messaging.</p> <p>The Cancer Alliance has commissioned the Roy Castle Lung Cancer Foundation to deliver x18 community engagement events in 2024/25 to support the uptake of LHCs. In July 2024, there is an event planned at a local Mosque during Friday Prayers to promote uptake amongst the Muslim population. We have translated a number of resources in Urdu, Bangladeshi, Arabic, Punjabi, and Polish based on feedback from locality-based colleagues. MFT has recently employed a community engagement facilitator to work within the service. Their role will be to work with local community organisations to increase awareness about the programme.</p>
	Maximising uptake of follow-up scans	<p>68 scanning days were allocated to surveillance and incident scans during Q1. FU scanning activity is well organised and managed. Where possible, the mobile scanners return to the same location where the prevalent screening round took place to facilitate uptake. 'Always on' paid social media advertising runs in areas following the completion of prevalent screening. Uptake of incident screening rounds will be monitored through the new MI metrics. Adherence to surveillance pathways is not raised as an issue from our providers</p>
Q2	100% rollout plans	<p>During the last quarter, the GM TLHC programme has continued to expand into new PCNs across the cancer alliance. Although we remain below our original trajectories, we are consistently delivering 1,300 to 1,500 LHCs each week and the service continues to operate 6 days/week 8am to 8pm. The cancer alliance monitors performance on a weekly basis and works with providers to increase attendance. By the end of 24/25, we hope to have invited 50% of the eligible population from our expansion cohort in addition to the P1/P2 projects. Primary Care engagement remains strong and there has been no impact from the BMA collective action. Data sharing agreements continue to be signed and returned.</p> <p>At present, there are no plans to increase our CT capacity although more detailed modelling is required to determine what activity looks like as we approach the end of our rollout.</p> <p>From April 2025, there will be a single provider for the TLHC programme in Greater Manchester (ICB/CA). Work is progressing with the current provider to ensure the safe transfer of patients.</p> <p>More detailed modelling work is being carried out with BI input to determine future invitations, as per the NHSE request for revised 100% rollout plans.</p>
	Uptake of LHCs	<p>We continue to deploy our multichannel comms as we expand to new PCNs as part of our rollout. This includes the use of paid social media, out-of-home advertising, local press, VCSE engagement, and community events. Some specific examples from the previous quarter involve communicating with the Jewish</p>

		<p>community through hyperlocal Facebook groups and the local synagogues, focusing particularly on communicating that appointments on the Sabbath (Saturday) can be rebooked for a more appropriate day. MFT have also been running an interactive SMS text messaging pilot to improve uptake and slot utilisation. We hope to see the results from this soon.</p> <p>Uptake has been particularly strong in certain PCNs (>65%). We would like to do some further work to better understand why uptake is so high in specific areas and to determine if there is a relationship between the demographic profile of the PCN and attendance/conversion etc.</p>
	Maximising uptake of follow-up scans	<p>43 scanning days from our mobile clinics were allocated to surveillance and incident scans during Q2 bringing the total YTD to 111 (excluding activity from our smaller project). Mobile scanners continue to return to the same location that was used during the prevalent screening round but we are now looking to consolidate activity within localities to ensure the best utilisation of assets. Transport is provided for all FU scans on the request of patients to facilitate uptake. July's MI report shows 100% compliance with LDCT standard 4, indicating that patients are being offered incident screening rounds in accordance with the standard protocol. It is anticipated that our activity mix will change in 25/26 and 26/27 as more people will be due their T1 scans.</p>
Q3	100% rollout plans	<p>Progress continues to be made towards the 100% population coverage target with 57% (Oct-24) of GP practices now onboarded onto the programme with their eligible patients having received at least a first invitation for a lung health check. Engagement remains strong with support from place-based colleagues to resolve locality issues. Our current planning shows that expansion activity will continue into FY 26/27 but this doesn't yet account for the aging in population. Further work is required to determine the best approach to this to ensure sustainability and effective use of resource.</p> <p>Trajectories for 25/26 have been drafted and are being reviewed by the cancer alliance, ICB colleagues, and provider organisations to ensure that plans are ambitious yet fully achievable as to mitigate income risks. At present, there are no plans to increase our CT capacity for 2025/26 however we are planning to achieve greater utilisation from our existing assets due to a shift in case mix. From April 2025, there will be a single provider for the TLHC programme in Greater Manchester, Manchester Foundation Trust. Work is progressing with the current provider to ensure the safe transfer of patients and that TUPE processes are being followed.</p>
	Uptake of LHCs	<p>Aggregate invitation and attendance data for April 2024 – October 2024 shows an uptake of 54.3% with this figure likely to rise as invitations are sent in advance with the LHC appts yet to happen (pathway data not available). In localities/PCNs where activity has concluded, we are able to view static data which provides a more accurate figure in relation to uptake. High uptake has been seen in Whitefield (63.6%), Farnworth (65.7%) and Tame Valley – Stockport (63.5%). Collaborative working across local NHS teams, local authorities, and the VCSE sector were a common theme across these 3 PCNs. It remains challenging to predict uptake but we are using a variety of data and local insight to best engage with local audiences. Our standard comms offer continues with paid social media, OOH advertising and other media buying where possible. The GM Cancer Alliance coordinated the NHSE TLHC story with strong media coverage across the</p>

		BBC in November 2024. This national coverage led to a spike (>x2) in visits to the provider website. We have also commissioned and produced a new 'come with me' video for use across a range of channels.
	Maximising uptake of follow-up scans	<p>MI data up until October 2024 shows a 96% uptake rate for incident screening rounds. This is slightly below the national average of 97.6% however there are known issues when calculating this metric due to it's introduction in April 2024 (numerator and denominators from different reporting periods). Further work is being carried out by our provider organisations to improve the data quality for metric 6b in relation to the uptake of nodule scans.</p> <p>October's MI report shows 100% compliance with LDCT standard 4, indicating that patients are being offered incident screening rounds in accordance with the standard protocol however this field is underreported at present. Improvements to reporting are being worked through at present and we hope to see better quality data in Q4.</p> <p>Transport is provided for all FU scans on the request of patients to facilitate uptake however this isn't offered as standard. 172 scanning days have been allocated to surveillance and incident scans up until the end of December 2024.</p>
Q4	100% rollout plans	
	Uptake of LHCs	
	Maximising uptake of follow-up scans	

Updates against quarterly milestones *(Use this space to confirm if progress is in line with milestones set in the 24/25 Alliance plan, and if/why any need to change.)*

Q1	In April 2024, 2 additional mobile CT scanners were mobilised as part of the GM TLHC programme. This has created additional LHC and CT capacity to service the rollout. The service continues to operate Monday to Saturday, 8am to 8pm. The launch of the digital communications campaign has been delayed due to challenges with coproduction.
Q2	Progress in line with milestones set at the start of FY.
Q3	Progress in line with milestones set at the start of FY.
Q4	

Risks *(Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)*

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
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Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) If the planned trajectories for LHCs and CT scans are not met, then the allocated revenue funding will be adjusted in line with actual delivery by NHSE, creating a potential cost pressure for the ICB and provider organisations. *Adherence to trajectory has improved throughout the year with August/September showing an improved position over Q1 and Q2.				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) Weekly performance monitoring of programme activity to have early indications of variance to plan Monthly provider operational delivery group with executive representation to discuss performance against trajectories Enhanced comms and engagement activity to support uptake and attendance				

3.3 Faecal Immunochemical Testing (FIT)

Deliverable	<ul style="list-style-type: none"> 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 <10ug/gm, normal full blood count and normal examination Support expressions of interest process to select pilot sites to participate in the bowel cancer screening programme FIT@80 pilot programme.
Success measures	<ul style="list-style-type: none"> CAN-02: Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result against agreed trajectory Percentage of LGI FDS referrals that at clinical triage fall into the following FIT bandings: <10 ug/gm; 10 – 100 ug/gm; >100ug/gm; No FIT available; FIT not appropriate, FIT available but no numerical value Percentage of colonoscopies performed on the LGI FDS pathway relative to FIT bandings: <10 ug/gm (against agreed trajectory); 10 – 100 ug/gm; >100ug/gm; No FIT available; FIT not appropriate, FIT available but no numerical value

Narrative quarterly updates *(Please outline work that has been carried out to ensure that: (1) FIT-led triage takes place in primary care for all appropriate NG12 patients, as per NICE DG56 guidance; (2) If patients are referred by a GP into secondary care without a FIT, FIT triage takes place in secondary care instead; (3) Alternative pathways are in place to manage patients with a FIT <10; (4) Colonoscopies taking place without a FIT and in FIT <10 patients are minimised; (5) Any FIT@80 pilot sites are being supported to reduce their BCSP referral threshold to 80 and fulfil their pilot commitments; (6) Healthcare inequalities are identified and addressed)*

Q1	<p>IIF data issue now resolved, latest position (Mar 24) shows GM at 68% of LGI referrals accompanied by a FIT result (CAN-02). Engagement with PCNs to support improvement continues, aided by the Primary Care Facilitator roles who are building closer relationships with a number of practices across GM and focusing on those with lower compliance.</p> <p>Secondary Care provider data shows current position of 17% of colonoscopies performed with no FIT result (Q4 2023), this trend continues in a positive direction. The Cancer Alliance Lead for FIT will continue to attend a Lower GI Endoscopy Task and Finish group to ensure engagement with the FIT pathway remains.</p> <p>Improving Early Diagnosis for Symptomatic Colorectal Cancer Task & Finish Group set up to engage a number of key stakeholders on the subject and oversee a programme of work. This includes a targeted community awareness and education project that will utilise a mobile van to increase engagement with FIT, which is in planning. The Cancer Alliance Colorectal Pathway Board and Early Diagnosis team also continue to progress plans to pilot a direct LGI USC referral from a pathology laboratory informed by a patients FIT result (FIT≥10)</p> <p>Ongoing work to support primary care clinicians including plans to design and deliver appropriate education modules via the Gateway C platform and continue to develop clinical decision support tools for GPs to increase FIT awareness.</p> <p>The Cancer Alliance continues to support FIT navigator roles in secondary care to increase compliance</p>
Q2	<p>Latest CAN-02 position (Aug24) places GM at 72% which is a small improvement on the 68% quoted above from March 24. We are aware of a data quality issue impacting the Tameside locality as a result of a system transfer meaning their performance has fallen from 62.2% in June 24 to 39.4% in August. We hope when this is resolved the overall GM figure will continue to improve.</p> <p>Our Primary Care Facilitators continue to work closely with PCNs and practices, using data to target localities that need further support to improve their IIF performance.</p> <p>Performance against the number of colonoscopies performed on patients without a FIT or with a FIT <10 is a key area of focus for our Endoscopy network with good practice being shared between providers. We have seen a significant improvement on colonoscopies performed on patients without a FIT with the most recent data showing the position at 9.2%, down from 17.1%. Focus will remain to support the improvement on Colonoscopies performed on patients with a FIT <10.</p> <p>The Cancer Alliance and Endoscopy Network are supporting Trusts to transition to NEDi2.1 with at least one more provider coming online before the end of the year.</p> <p>The Early Diagnosis for Symptomatic Colorectal Cancer Task & Finish Group is underway and planning for a community outreach, awareness and education project is progressing. We expect the Colorectal Cancer “This Van Can” to be on the road before the end of the calendar year, and it will travel around GM delivering awareness and education messaging on LGI Cancer signs & symptoms, FIT, and Bowel Cancer Screening.</p> <p>The Early Diagnosis Task & Finish group are also working on the feasibility of a pathway whereby positive FIT results would be picked up within the pathology lab and patients referred internally onto the appropriate hospital waiting list rather than being sent back to the GP for a referral to be made.</p>

Q3	<p>CAN-04 position for Nov 24 puts GM at 79.7%, representing a 7.7% increase on August's figures. This is just shy of the 80% target and we hope to see this positive trend increase with further targeted work and the ongoing, colorectal This Van Can Project. We are also aware of data quality issue in the Tameside locality due to a system change, this impacted all PCNs in the locality, with one now having resolved this issue we expect the other to follow suit, which should hopefully tip GM over the 80% target.</p> <p>We are working with our primary care facilitators, using data, to target areas that may need more support to ensure all PCNs are moving in a positive direction, including supporting those in Tameside to resolve their data issue.</p> <p>FIT negative colonoscopies remain an area of focus, updates are provided at our Endoscopy network and pathway boards to ensure best practice is shared. In the last quarter, MFT have gone from one of the lowest performers nationally >30% to 10.5%.</p> <p>Our colorectal This Van Can, community outreach project launched 28/11/24 and has so far delivered 12 events across 4 weeks in our Manchester and Salford localities and will continue through to the end of April this year. In those first 4 weeks we saw positive engagement from our communities with the project, interacting with over 2000 individuals, completing over 650 surveys and ordering approximately 100 screening test kits for eligible individuals who had not otherwise completed.</p> <p>The Early Diagnosis Task & Finish group remains active with a focus on creating a wider programme of work across the pathway, including focused comms work to tackle health inequalities and a FIT direct to referral pathway pilot in our labs.</p>
Q4	

Health Inequalities updates *(Please provide a brief update with regards plans to address Health Inequalities as part of this work. Alliances should focus updates on how they are using PCN IIF data to identify trends in uptake, how they have worked with PCNs to address variation in uptake, and how they have developed patient education and netting approaches to follow up with those who have not returned a kit.)*

Q1	The Cancer Alliance has identified the LGI pathway as a priority for Early diagnosis in 24/25 and will oversee a community outreach project through the aforementioned task and finish group. This work aims to promote the awareness and importance of FIT using data to target areas where late-stage diagnosis and emergency presentations are highest as well as where FIT uptake is lowest via a mobile van. This will also explore how health inequalities impact the likelihood of invalid tests and provide education.
Q2	<p>A health inequalities insights project has been undertaken at one of our providers to understand how inequalities may impact FIT results. We are exploring this further with a view to look at this GM wide.</p> <p>As mentioned above, we expect the colorectal "This Van Can" project to be live before the end of the year. We are using data and locality knowledge to target areas of greater need and will be considering how we can address inequalities through variety and accessibility of messaging both delivered on the van and with the comms and engagement campaign that accompanies.</p>
Q3	Our colorectal This Van Can project is now on the road, heading into communities where late stage diagnosis is greater to provide targeted awareness raising messaging and education. As part of this project we have utilised the support of locality colleagues to focus in on specific communities. Building on this, we are exploring plans to create a bespoke comms campaign for those communities we know are unlikely to engage with the van, working with community champions to ensure appropriate messaging and language
Q4	

Risks *(Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)*

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) Data quality issue in Tameside locality effecting overall GM figures.				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) The cancer alliance has made affected PCNs aware and are working with them via our primary care facilitators to ensure the data issue is resolved. 1 of the 5 PCNs in the affected area has since solved the problem and learning is being shared to allow the remaining 4 to do the same.				

3.4 Liver Surveillance

Deliverable	<ul style="list-style-type: none"> Cancer Alliances to support Liver Services to invite >80% of patients with cirrhosis/advanced fibrosis to 6-monthly ultrasound surveillance and support >60% of those invited to attend
Success measures	<ul style="list-style-type: none"> Number of people identified as at high risk of liver cancer (with cirrhosis/advanced fibrosis/hep B) who are suitable for surveillance against agreed trajectory Number of people invited to liver ultrasound surveillance within the last six months against agreed trajectory Number of people who have attended liver ultrasound surveillance within the last six months against agreed trajectory

Narrative quarterly updates

Q1	Hepatology nurse recruited. Hepatology navigator posts either recruited or out to recruitment in all Trusts. Data reporting ongoing for 3 Trusts, with processes put in place to begin data reporting in Q2 in remaining Trusts. Hepatology Network established in Q1, with first meeting taking place in July. Content of patient information leaflet finalised, pending final sign off at Hepatology Network meeting.
Q2	Hepatology navigators recruited and in post in most Trusts. Navigators have helped in collating liver surveillance registers, which will ensure Trusts are reporting data in Q3. First Hepatology Network meeting took place, with representation from every Trust. Gap analysis performed on local liver surveillance guidelines against NHSE guidelines. Patient information leaflet wording finalised and sent to design agency. MFT are looking into EPIC for recall system. The new radiology code has been shared with Trusts. We will assess if the code is being used at the next hepatology network meeting in November.
Q3	Two Trusts (MFT and Tameside) have started to build a recall system within their existing electronic patient record system. The remaining Trusts have confirmed that we will use the radiology system for recall. Radiology code was being used across some Trusts but not all, so meetings arranged with local hepatology and radiology leads to embed the use of this code. Strong engagement with clinical and operational management teams.
Q4	

Updates against quarterly milestones *(Use this space to confirm if progress is in line with milestones set in the 24/25 Alliance plan, and if/why any need to change.)*

Q1	Local liver surveillance guidelines embedded in all Trusts. First Hepatology Network meeting taking place in July.
Q2	3 Trusts reporting data. Hepatology navigators in post to support data collection in Q3. MFT using smart form template in EPIC.
Q3	As outlined above, MFT and Tameside recall system in development with intention to implement / go live in Q4.
Q4	

Risks (Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) Navigator retention and recruitment has been difficult, which has an impact on data reporting. Implementation of the recall system is dependent on IT system upgrades therefore out of the direct control of the clinical and operational teams.				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) Navigator retention and recruitment will be discussed at the next hepatology network meeting. The use of the radiology code will support in collecting data in the future. Internal Trust discussions between clinical / operational teams and IT system leads – Cancer Alliance updated via regular project meetings and can escalate as GM IT system issue if required.				

3.5 Pancreatic Cancer – EUROPAC

Deliverable	<ul style="list-style-type: none"> Coordinate with EUROPAC navigators to refer 500 patients (nationally) at high risk of hereditary pancreatic cancer into the EUROPAC surveillance programme
Success measures	<ul style="list-style-type: none"> Number of enrolments and number of cancers diagnosed, to be provided by EUROPAC directly

Narrative quarterly updates *(Please include information on the steps you have taken to develop and improve referral pathways from secondary care, genetic services and primary care into EUROPAC surveillance and what steps you have taken to support the regional navigator if referrals have remained low.)*

Q1	EUROPAC healthcare professional briefing referral form have been shared with HPB pathway board. EUROPAC has been presented at the Primary Care Network Cancer Leads meeting and included in the monthly PCN bulletin to encourage referrals from primary and secondary care.
Q2	Regular meetings held between cancer alliance and genetics services to discuss ongoing concerns with EUROPAC. Attendance at national share & learn meeting. Referral form and EUROPAC presentation re-shared with HPB pathway board to increase referrals from secondary care.
Q3	Online family history checker shared on cancer alliance social media platforms, along with other assets in pancreatic cancer awareness month. Inherited Risk Resources Hub shared with HPB pathway board. The majority of referrals are via the self-referral route, which is in keeping with other cancer alliances nationally
Q4	

Risks *(Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)*

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) Local genetics services continue to have concerns regarding EUROPAC, such as no published data and concern over the genetic tests being performed within the study				

Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter)

The Cancer Alliance is aware that EUROPAC plan to publish before the end of the year. This publication will be shared with regional genetics team and arrange a meeting to discuss the publication. Regular meetings between Cancer Alliance and Genetics services to update on any discussions that take place between EUROPAC and UK Cancer Genomics Group

3.6 Community Pharmacy Pilots (for those Alliance participating)

Deliverable	<ul style="list-style-type: none"> Delivery of urgent suspected cancer pharmacist referrals pilot sites with 20 or more pharmacies in each locality, contributing to the national evaluation to inform a recommendation for future commissioning of service.
Success measures	<ul style="list-style-type: none"> Number of community pharmacy consultations resulting in cancers found Stage of cancers found through community pharmacy pilots.

Narrative quarterly updates *(updates should describe activities made against agreed plans and why any changes may have been made)*

Q1	One locality in GM has gained the necessary approvals from all stakeholders to go live with the pilot. Currently, there are 12 community pharmacists in the locality who have completed the required expressions of interest and have been approved to be included in the pilot. As the pilot gathers momentum it is anticipated that there will addition CPs wanting to be included. The protocols and pathways for the pilot have been signed off and the Service Level Agreement (SLA) finalised. Work is progressing to support CPs to go live by the end of the quarter and this includes signing up to deliver the service via the SLA undertaking the necessary training. A pharmacist has been engaged to support the delivery of the pilot and they will be working directly with the pilot sites.
Q2	The pilot has gone live and participating CPs are being supported by a pharmacist on the ground in partnership with Community Pharmacy Greater Manchester. A webinar was held for CPs participating in the pilot and was also attended by lead clinicians from the trust. There remain 12 Community Pharmacists committed to the pilot, and there has been interest from other CPs to join the pilot. The Alliance will be monitoring progress and have committed to hosting another event for all participants that will be held in Q3.
Q3	The pilot has gone live and participating CPs are being supported by a pharmacist on the ground in partnership with Community Pharmacy Greater Manchester. A further webinar to support and engage CPs participating in the pilot has been planned for Q4. There remain 12 Community Pharmacists committed to the pilot. The Alliance will be monitoring progress – there has been 1 consultation to date. However, this was for a person registered with a GP outside of the pilot area.
Q4	

Health Inequalities updates *(Please provide a brief update with regards plans to address Health Inequalities as part of this work. Updates should focus on how the Alliance are prioritising those living in more deprived areas and who are less likely to seek advice from a GP.)*

Q1	CPs have self-selected to be part of the pilot, and this presents challenges for prioritising communities with the greatest levels of deprivation for which such a pilot has the potential for providing significant benefit. Work will be undertaken to monitoring uptake across all sites and efforts made to work with those CPs where uptake is low including those in areas of greatest deprivation
Q2	Work is ongoing to monitoring activity by all CPs involved in the pilot and efforts will be made to work with those CPs where uptake is low including those in areas of greatest deprivation.
Q3	Work is ongoing to monitoring activity by all CPs involved in the pilot. However, activity has been low and as such would not necessarily inform any development work at this stage.
Q4	

Risks *(Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)*

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) Some CPs have been slow to engage with the mandatory training and to self-certify completion which is necessary prior to referring patients				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) The local task and finish group have been informed of progress and visits to all CPs by the pharmacists engaged to support the pilot are progressing with CPs being prioritised where they have not yet completed the training.				

4 Workstream: Local Early Diagnosis Initiatives

4.2 Screening

Deliverable	<ul style="list-style-type: none">• Work with NHSE Regional Public Health Commissioning Teams and local partners to develop and deliver plans to increase uptake and coverage of the NHS breast cancer, bowel cancer and cervical screening programmes.• Work with Regional public health and local authority commissioners to develop and deliver plans jointly with local system partners to encourage the uptake of HPV vaccination in the catch-up cohorts.
Success measures	<ul style="list-style-type: none">• Cancer Alliances should set own metrics to measure success of activities to promote uptake.

Narrative quarterly updates

Q1	<p>With input and support from the Mayor of GM, the Cancer Alliance and the NHSE Screening & Immunisation Team are to develop a focused programme of interventions to improve the delivery and uptake of breast screening.</p> <p>Joint work with NHSE SIT colleagues to improve uptake of the post-FIT pathway for patients with positive screening results and reduce the drop off rate for this pathway.</p> <p>Screening Improvement Leads now have a regular agenda item on the breast, gynae and colorectal pathway boards to present the latest position on and work programme for the 3 cancer screening programmes.</p> <p>Joint work on a FIT screening and symptomatic community engagement and awareness outreach programme to commence October 2024 – planning underway led by the Cancer Alliance with input from the SIT.</p> <p>Cancer Alliance communications team to provide support to the NHSE SIT for patient / public comms on the 3 cancer screening programmes and HPV.</p> <p>Primary Care & Early Diagnosis Facilitators working together with the Cancer Screening Improvement Leads to address issues re uptake at a PCN and Practice level,</p> <p>New data flows developed which will provide PCNs with data to support improvement projects</p>
Q2	<p>The Cancer Alliance Communications and Engagement team have agreed a clear plan and programme of work with the NHS GM SIT to provide the public and patient facing communications re the 3 cancer screening programmes and HPV in 2024-25. This has already commenced in Q2 with a focused campaign on cervical screening for the LGBTQIA+ community and planned activity for September to highlight breast cancer screening in breast cancer awareness month. These activities are funded in part by NHS GM and in part by the Cancer Alliance using the funding included in the Timely Presentation allocation (see Part 2 of 2).</p>

	<p>The Cancer Alliance are launching a mobile community outreach project to highlight lower GI symptoms and the importance of bowel cancer screening. The SIT Cancer Screening Improvement Leads are involved in the development of this project and will play an active role in the delivery. This is due to go live in early Q3.</p> <p>SIT Screening and Immunisation Managers now routinely attend the Cancer Alliance Pathway Board meetings for Breast, Colorectal and Gynae to provide an update on the cancer screening programmes. These updates include the latest uptake data, any risks to delivery and details of programmes of work relating to the delivery and uptake of the programmes.</p> <p>Primary Care & Early Diagnosis Facilitators continue to work with the Cancer Screening Improvement Leads to address issues re uptake at a PCN and Practice level, using the data which is now live on the GM Curator system, showing more timely data on the update of screening programmes at a practice and PCN level.</p> <p>In Q3 there will be a spotlight on screening programmes at the Cancer Alliance Programme Assurance Group.</p> <p>Work continues on the 'blueprint' for breast cancer screening in line with the request from the GM Mayor – the NHS GM SIT are leading on this process with clinical and managerial input from the Cancer Alliance.</p>
Q3	<p>The Cancer Alliance Communications and Engagement team continue to deliver against the agreed plan and programme of work with the NHS GM SIT to provide the public and patient facing communications re the 3 cancer screening programmes and HPV in 2024-25. This has included to date some generic information along with some approaches targeted at particular communities, patient groups and age groups. There was extensive activity in September and October to connect with breast cancer awareness month. This included the use of case studies based on residents of Greater Manchester diagnosed with breast cancer, from a range of demographic groups. In November 2024 the Cancer Alliance launched the mobile community outreach 'This Van Can' project to highlight lower GI symptoms and the importance of bowel cancer screening. The SIT Cancer Screening Improvement Leads are involved in the project and provide live access to the SIT system, enabling the ordering of screening FITs for patients who report having lost or damaged the kits received. SIT Screening and Immunisation Managers now routinely attend the Cancer Alliance Pathway Board meetings for Breast, Colorectal and Gynae to provide an update on the cancer screening programmes - updates include the latest uptake data, any risks to delivery and details of programmes of work relating to the delivery and uptake of the programmes.</p> <p>Primary Care & Early Diagnosis Facilitators continue to work with the Cancer Screening Improvement Leads to address issues re uptake at a PCN and Practice level, using the data which is now live on the GM Curator system, showing more timely data on the update of screening programmes at a practice and PCN level.</p> <p>The planned spotlight on screening programmes at the Cancer Alliance Programme Assurance Group did not take place in Q3 but is scheduled for February 2025.</p> <p>Work continues on the 'blueprint' for breast cancer screening in line with the request from the GM Mayor – the NHS GM SIT are leading on this process with clinical and managerial input from the Cancer Alliance.</p> <p>The Cancer Alliance have commissioned and produced a 'Focus On' educational video for GM on cancer screening, delivered by the clinical lead for the GM SIT and launched in the PCN Cancer Leads briefing session in December 2024. Now widely available to primary care professionals.</p>
Q4	


Risks (Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)


Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) Risk could be patient and public uptake and engagement. Variation across the PCNs in GM in relation to screening uptake				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) Joint work between the Cancer Alliance and Screening & Immunisation Team at a strategic and operational level continues. NHSE SIT Lead is a member of the Cancer Alliance Programme Assurance Group giving monthly updates on screening programme and also meets with the Director of Commissioning & Early Diagnosis on a fortnightly basis. The SIT are represented in the Cancer Alliance Early Diagnosis Programme Board. The GM Cancer Alliance comms and engagement team are represented in the weekly NHS GM communications meetings to ensure alignment with the public and patient facing messages re screening. Primary Care and Early Diagnosis Facilitators continue to discuss screening uptake with PCNs. Focus On video produced for primary care professionals, focusing on screening				

4.3 Timely Presentation

Deliverable	<ul style="list-style-type: none"> Set out Timely Presentation objectives, informed by data and insights, with a particular focus on the most disadvantaged 20%. Deliver programme of campaigns, community engagement and partnership activity to increase symptom knowledge and encourage earlier presentation, which link where appropriate to national Help Us Help You campaigns. Establish metrics to measure achievement of objectives and review tracking regularly.
Success measures	<ul style="list-style-type: none"> Cancer Alliances should set own metrics to measure achievement of Timely Presentation objectives. The Government Communications Service Evaluation Framework 2.0 provides a structure for a monitoring and evaluation plan including outputs, outtakes, outcomes and organisational impact that you can apply to your local activity.

Narrative quarterly updates (Please enter the metrics you have established and provide quarterly updates on progress. Please use the row on 'overall updates' to briefly explain the overall progress being made against plans. Please enter brief details about the specific activities you are running in separate rows, clarifying their objectives and associated metrics. You can add extra rows if needed. Please ensure that any activities being delivered in support of screening uptake are reported separately in section 3.1)


Q1	Overall updates	<p>Ongoing design and delivery of a wide ranging and clinically led programme of early diagnosis patient facing comms in a variety of formats.</p> <ul style="list-style-type: none"> Continued “always on” early diagnosis campaign messaging via use of paid social media, organic social media and monthly campaigns calendar shared with stakeholders, including: <ul style="list-style-type: none"> Out of home advertising – National generic cancer barriers creative across GM (with weighting to areas of high deprivation) – outdoor display posters, YouTube advertising and Radio (DAX). Media – pieces in Manchester Evening News and various local titles (sponsored and earned) supporting campaigns outlined below plus NHS Galleri. Social Media – paid and organic activity to support campaigns outlined below plus general symptom awareness messaging. <p>An overview of some Q1 activity and stats can be seen in the appendix document attached</p> <div>  <p>Comms Appendix Q1 24-25.pptx</p> </div>
	Activity 1 [replace with objectives and agreed metrics]	Lung: Supporting TLHC communications activities and ongoing social media advertising for self-referral chest x-ray in HMR / Bury.
	Activity 2 [replace with objectives and agreed metrics]	<p>Urology: haematuria campaign launched Q1, including out of home advertising, (bus sides and public bathrooms) radio, social media (paid, organic and via partner organisations), engagement assets (posters, flyers) sent to VCSE organisations and primary care colleagues.</p> <p>Promotion of existing prostate awareness social media assets following successful case finding project in 2023-24</p>
	Activity 3 [replace with objectives and agreed metrics]	Upper GI: Public campaign developed and launched in Q1 including out of home advertising (billboard posters and pharmacy bags) radio, social media (paid, organic and via partner organisations), engagement assets (posters, flyers) provided to VCSE organisations and primary care colleagues.

Q2	Overall updates	<p>Continued ‘always on’ early diagnosis campaign messaging via use of paid social media, organic social media and monthly campaigns calendar shared with stakeholders. 29 paid adverts. Media stories and interviews across a range of titles.</p> <p>Social media highlights:</p> <p>36 paid ads Total reach: 563,397 16,468 link clicks Average cost per click: 47p Total spend: £7,900</p> <p>Campaign assets also distributed to partner organisations via our comms calendar, generating 1,500 clicks to download assets over 3 months.</p> <p>Full stats provided in attached appendix.</p>  <p>Q2 Stats roundup for Comms and Engagem</p>
	<p>Activity 1</p> <p>Objective</p> <p>Continued support of TLHC across various comms channels – to support and improve attendance.</p> <p>Metrics</p> <p>Standard outputs from social media /</p>	<p>Lung – continued activity to support TLHC roll out</p> <ul style="list-style-type: none"> Two pieces of local media coverage in the Oldham Times and Bury Times which have a readership of around 6,408 and 3,616 respectively. Also amplified on their Facebook and X accounts which have 40K/5k and 77k/18k followers. OOH in four target areas (Oldham, HMR, Whitefield and Stockport) delivering an estimated 3.6 million impressions 12 Facebook ads. Targeting: 55+ men and women in selected postcodes of GM where the trucks was parked up. 194 organic posts about the Lung Health Checks on X and Instagram from the Alliance account and stakeholders using our comms toolkit to spread the word resulting in 528,000 impressions during Q2. Visits to the main MFT Lung Health Check website were about our monthly KPI average each month sitting at around 2,500 visits per month. <p>EVALUATION:</p>

<p>media. Key metrics around attendance figures.</p>	<p>Outputs:</p> <p>Our paid social media in this period had garnered 1,267,161 impressions and reached 176,416 people during Q2. Over 9,000 clicked on a link for further info at an average cost per click of 34p (lower than the Alliance average currently sitting at 47 pence per click). These adverts scored an engagement rate of 1.20% - which sits above industry standard (<i>Engagement rate above 1%= good, 0.5%-0.99% is average; below 0.5% engagement likely means that you need to realign your message</i>)</p> <p>Outtakes:</p> <p>Many of the paid adverts had messages from people saying they had booked an appointment or thanking staff for the service.</p> <p>Outcomes:</p> <p>There have been sustained improvements in attendance within the TLHC programme in GM over the quarter with 18,626 lung health checks performed in the last quarter alone (vs. Q1 13,380 (+5,246)). GM achieved 93% of their planned LHCs in September. This is an improved position in comparison to Q1 at 74% to 78% of plan. Attendance rates vary across the 4 units based on the local population with some areas experiencing higher than anticipated demand at 90+ LHC appts/day. In one week alone, over 1,600 people attended a LHC across the Cancer Alliance. We have seen attendance of up to 70% in some Primary Care Networks. The NHSE KPI is 53%.</p>
<p>Activity 2 Objective:</p> <p>Support Gynaecological Cancer Awareness Month with a range of messaging to increase awareness of signs and</p>	<p>Gynae</p> <p>Support of gynae cancer awareness month in September, and some reactive activity following ovarian cancer storyline on Coronation Street:</p> <ul style="list-style-type: none"> • Paid advertising & organic social to go with Coronation Street ovarian cancer storyline in August (Reach 54,857, Engagement – 41.2% (extremely high), cost per click – 64p (higher than average). The advert sparked a range of comments from our audience including: “I was diagnosed with stage 3a2 ovarian cancer January 2023 just before I turned 43. It was found when I had a hysterectomy for chronic endometriosis. I'm 12 months clear and recovering well.” And: “I was diagnosed at 52....a swollen tummy which my G.P didn't like & sent me for a scan. It was aggressive with a

<p>symptoms of various gynae cancers.</p> <p>Metrics</p> <p>Standard outputs from social media / media. Looking for evidence of members of the public improving knowledge levels via good engagement rates.</p>	<p>10cm mass in my Ovary. A full Hysterectomy followed with a small amount of Chemotherapy. Eleven years have passed and I am fit & healthy. That GP is one of my heroes as is The Christie.”</p> <p>A full list of comments is available here:</p> <div data-bbox="689 316 745 379" data-label="Image"> </div> <p>Ovarian comments for Q2 return.pptx</p> <ul style="list-style-type: none"> Detailed work to highlight gynae cancers including working with OUTpatients to promote their social media campaign to Remove the Doubt around cervical screening for LGBTQIA+ groups and with NHS NW to promote Nadia Ali Ross, Clinical Lead for Gynae, as a social media, web article and media spokesperson promoting cervical screening amongst ethnic minorities. Social media advert using signs and symptoms of cervical cancer animation achieved a reach of 32,417, an engagement rate of 17.7% (very good) and a cost per click of 27p. (below average). Article in the Asian Leader featuring Nadia Ali Ross on the importance of attending cervical screening. Nadia also spoke in depth to North Manchester Asian radio station Crescent Radio (potential audience 25,000 people) about womb, ovarian and cervical cancer. Video content clips from interview subsequently performed very well on social media. (800 plus views on organic channels) Advert about cervical cancer symptoms on Legacy FM – local radio station for the African and Caribbean community.
<p>Activity 3</p> <p>Objective: Support other priority pathways</p> <p>Metrics - Standard outputs from social</p>	<ul style="list-style-type: none"> Colorectal - Amplification of messaging for key cancers including Bowel Cancer UK's new Tell Your GP Instead campaign and a new edit of the Alliance how to do a FIT test video. (combined reach – 76,000 with engagement for both sitting around 45%) Head and Neck - Amplification of the NHS & Asda mouth cancer symptoms campaign.

	media / media. Looking for evidence of members of the public improving knowledge levels via good engagement rates.	<ul style="list-style-type: none"> Stories across 6 titles including the Manchester Evening News, MSN News, Yahoo News, Bolton News and Oldham Chronicle on NHS/Asda partnership. Greater Manchester patient case study Steve also supported with NHS NW using our video. Skin - New sun safety assets to tie in with the Euros and the Olympics used and shared with partners over July and August Further social spend on OG and Urology Blood in Pee campaigns on social media.
Q3	Overall updates	<p>Launch of This Van Can bowel cancer awareness roadshow, travelling around all localities in GM across Q3 and 4.</p> <p>Supporting other priority pathways via activity linking into breast cancer awareness month and lung cancer awareness month. This included case studies in local newspapers, radio interviews with clinical leads and social media activity, as well as new animations with Urdu and Arabic voiceovers. During lung cancer awareness month “LungAware” was launched – a new online tool to help the public check their lung symptoms and decide on next actions.</p> <p>Continued support for Targeted Lung Health Checks as it rolls out across Greater Manchester. This included supporting a large amount of media activity generated by the programme achieving the “700 cancers diagnosed in Greater Manchester” milestone.</p> <p>We also carried out some communications to support non-specific cancer symptoms around the busy December period with an article in the Manchester Evening News with digital display boosting to reach those with a GM-postcode and some print adverts featuring the Help Us Help You campaign in the popular Christmas TV print supplement to target a non-digital audience. The Christmas Manchester Evening News story published on NSS gained 205,789 impressions and In Your Area advertising of 27,234 impressions.</p> <p>This quarter we generated:</p> <ul style="list-style-type: none"> 23 pieces of media coverage 12 targeted Facebook / Instagram adverts, reaching 845k people with an average engagement rate of 8.4% (well above industry standard) <p>Detailed stats and links to media coverage can be found in the document attached.</p>

		 <p>Q3 stats round up - timely presentation.pptx</p>
	<p>This Van Can Bowel Cancer Awareness Roadshow</p> <p>Objectives:</p> <p>Good attendance rates at the van.</p> <p>Standard outputs from social media / media.</p> <p>Looking for evidence of members of the public improving knowledge levels via good levels of attendance at the van as it travels around as well as good engagement on social media.</p>	<p>“This Van Can” bowel cancer awareness roadshow launched in late November and has visited Manchester and Salford localities so far. The van visits local communities, offering education and advice on bowel cancer signs and symptoms as well as bowel cancer screening.</p> <p>As well as supporting the design and development of the van itself and associated comms assets, we have promoted the launch using social media (targeted Facebook advertising and posting to specific local community groups), media (press and radio) and community engagement packs via NHS and VCSE colleagues.</p> <p>Outputs</p> <p>228 social media posts generated from our account and partners using the hashtag #ThisVanCan (138 posts) and #JoinTheBowelMovement (90 posts). Our content was seen approximately 400,000 times throughout November and December. 1,462 people engaged with the content. 3 pieces of media coverage were generated in December, including 2 press stories and a radio interview on Wythenshawe FM with colorectal clinical lead Dr Roger Prudham. Manchester Evening News article on bowel van gained 197,297 impressions and In Your Area advertising 17,866 impressions.</p> <p>Outtakes</p> <p>Initial metrics from the van are reporting both high attendance levels and a high proportion of good quality conversations with attendees. Both qualitative responses to attendee surveys and social media comments are overwhelmingly positive.</p> <p>Outcomes</p> <p>As the project is ongoing full outcomes are not yet available – however as per the outtakes above early statistics are promising that the project will achieve improved knowledge of early signs and symptoms, as well as improved screening uptake.</p>

	<p>Supporting other priority pathways (incl launch of “LungAware” online tool during Lung Cancer Awareness Month)</p> <p>Standard outputs from social media / media.</p> <p>Looking for evidence of members of the public improving knowledge levels via good engagement on social media.</p>	<ul style="list-style-type: none"> • LungAware: this online tool launched within lung cancer awareness month with a phased roll out of promotion in Bury, HMR, Bolton and Stockport, (four of ten localities) comprising targeted Facebook ads (still running), out of home media and community engagement packs (including posters and postcards). • Lung cancer awareness month activity included: social media coverage including signs and symptoms graphic and animation, quote tiles from patient reps Sally Hayton and Sally Hall. Targeted Facebook ad using signs and symptoms animation = 24,388 views. • Dr Louise Brown (clinical lead for lung cancer) was interviewed on Crescent Radio in Rochdale to talk about lung cancer general signs and symptoms, the LungAware tool, self referral to chest x-ray and targeted lung health checks. Crescent FM followed up this interview with a Whatsapp message to their group including useful links to all services discussed. • Breast cancer awareness month: we had new videos, translated animations and advertising on Crescent Radio (a radio station targeting predominantly South Asian audience in North Manchester) and Legacy Radio (a radio station targeting predominantly Black audience in South Manchester) as well as high-performing reels on socials featuring our breast cancer clinical lead Clare Garnsey’s interview. Animations produced with Urdu and Arabic voiceover, distributed via Cancer and Inequalities Network and performing well on YouTube. 6 videos were also made featuring senior leaders talking about the importance of both knowing the signs and symptoms of breast cancer and of attending your mammogram once invited which were share don our social channels. <p>Outputs</p> <ul style="list-style-type: none"> • 119 posts generated using hashtag #GMBreastCancer, with content being seen 312k times. 324 people engaged with content on this hashtag. • Targeted Facebook ad using animation on signs and symptoms of lung cancer generated 24k views. • 4,000 link clicks delivered from targeted Facebook ads for LungAware, reaching a total of 114k people. • Out-of home advertising in 4 localities to support LungAware is estimated to have generated 7 million impressions.
	<p>Ongoing support for Targeted Lung Health Checks</p>	<p>Greater Manchester reached “700 cancers found” milestone this quarter, and generated a large amount of media coverage as a result. This included Dr Haval Balata and a Greater Manchester patient Phil Bennett appearing on BBC Breakfast, BBC 5 Live, BBC News Channel and BBC North West amongst others. (see attached powerpoint above for all media links).</p>

	during roll out across Greater Manchester	<p>This resulted in an increase of web traffic to the Lung Health Check page and more calls to the booking line.</p> <p>Ongoing social media and out of home activity continued throughout the quarter to support the programme including engagement with the Jewish community through hyperlocal Facebook groups and the local synagogues, focusing particularly on communicating that appointments on the Sabbath (Saturday) can be rebooked for a more appropriate day.</p> <p>We also attended and provided a speaker who spoke in Urdu and English about the importance of attending your lung health check when invited at a community event organised in association with Health Innovation Manchester and community leaders.</p> <p>Outputs</p> <p>12 pieces of high-value, earned media coverage 143 posts on X(formerly Twitter and Instagram) by 44 different users (who receive a VCSE pack with wording about the Lung Health Checks to share on their channels) reaching approximately 128,157 people and garnering 340,661 impressions 11 paid Facebook Adverts including trying some new assets which we worked with Health Innovation Manchester to help appeal to ethnic minority audiences and to people with disabilities. Manchester Evening News article on TLHC gained 235,923 impressions and In Your Area advertising 17,881 impressions.</p> <p>Outtakes</p> <p>Increased visits to the lung health check web pages showing a strong correlation to the broadcast media coverage.</p> <p>Outcomes</p> <p>Increased phone calls to the booking line including from some patients who had had an invitation but not previously taken up their invite. Uptake has been particularly strong in certain PCNs (>65%) including the PCN with a high Jewish population.</p>
Q4	Overall updates	

	Activity 1 [replace with objectives and agreed metrics]	
	Activity 2 [replace with objectives and agreed metrics]	
	Activity 3 [replace with objectives and agreed metrics]	

Health Inequalities updates *(Please provide a brief update with regards to plans to address Health Inequalities as part of this work. Details should focus on which groups at risk of experiencing health inequalities were targeted, how they were engaged, and whether activity had any impact on these groups.)*

Q1	Comms activities outlined above have been driven by health inequalities data – amplifying messages and enhancing patient / public facing comms activities in the geographical areas and with population groups most at risk and most likely to present at late stage.
Q2	Comms activities outlined above have been driven by health inequalities data – amplifying messages and enhancing patient / public facing comms activities in the geographical areas and with population groups most at risk and most likely to present at late stage. In this quarter activity included promoting TLHC at a mosque event and via a Facebook community group specifically for the Jewish population in a certain area, supporting the LGBTQ+ community with targeted cervical screening comms, and targeting the Asian community with general gynae cancer awareness messaging via Crescent Radio amongst other activities.
Q3	Comms activities outlined above have been driven by health inequalities data – amplifying messages and enhancing patient / public facing comms activities in the geographical areas and with population groups most at risk and most likely to present at late stage. In this quarter activity included targeting the Asian community with messaging about breast and lung cancer on Crescent radio, production of breast cancer animations (for symptom awareness and breast checking) with Urdu and Arabic voiceover with distribution via the Cancer and Inequalities Network, working with the Jewish community to raise awareness of Targeted Lung Health Checks in Whitefield and working with mosque and community leaders to raise awareness of upcoming Lung Health Checks in Bolton. We worked with Health Innovation Manchester to try out some new social media assets for the Lung Health Check social media aimed at audiences from ethnic minorities and those with disabilities.
Q4	

Risks *(Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)*

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) Potential risk with the resignation of the Communications & Engagement Lead for the Cancer Alliance				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) Recruitment to this post with the new postholder scheduled to start mid September. 3 Communications & Engagement Managers in post who are continuing to deliver the programme of work reporting directly to the Director of Commissioning & Early Diagnosis pending the start date of the new Lead. January 2025 update: New Communications and Engagement Lead joined in September 2024.				

4.4 Primary Care Pathways

Deliverable	<ul style="list-style-type: none"> Work with Primary Care Networks (PCNs) and other primary care stakeholders as required, to outline a clear set of actions and milestones to improve referral practice for bowel, lung and one other tumour site as determined locally, supporting delivery of the early cancer diagnosis requirements in the PCN DES Provide local insights and input into the development of resources to support Cancer Alliances to implement local incentive schemes for primary care
Success measures	<ul style="list-style-type: none"> Narrative updates should be provided quarterly, in line with use of funds. Cancer Alliances should report which cancers they have developed action plans for and the steps they will be taking to improve referral practice as a result. Success will also be measured using the following metrics: Volume of GP requested chest X-ray tests (Diagnostic Imaging Dataset)

Narrative quarterly updates *(Please include information on how you are working with primary care stakeholders to deliver improvements in referral practice for the agreed tumour sites, focusing on the impact this work is having on improving early diagnosis rates. Please also highlight any evidence you have gathered on the impact of these interventions.)*

Q1	Lung	Work is ongoing in relation to Targeted Lung Health Checks and this is referenced elsewhere. As referenced below the Primary Care and Early Diagnosis Facilitators are supporting PCNs to include activity relating to this tumour site and when doing so to review the available data and engage with available resources and tools and
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	<p>the promotion of patient and public awareness. Development of the Think Cancer – clinical decision support tool continues and will include the identification of high risk patients (including those whose with persistent symptoms following a chest x-ray and 2+ courses of antibiotic in last 12 months for respiratory infections) to support onward referral.</p> <p>An e-learning module for Non-Medical Prescribers is now live and will be accompanied by a COPD tool for use by this staff group. Monitoring of chest x-ray (CXR) referral rates is now available via a dashboard, accessible via tableau, and has been shared. It is anticipated that the roll out of the HealthBot for use by patients and the public will also impact positively on CXR referral rates by increasing awareness in this group</p>
Bowel	<p>The Facilitators, as part of the development of action planning with PCNs have made available to them monitoring data relating to this tumour site and will be working with the locality screening leads to progress measures to increasing uptake of the screening programme. In addition, monitoring data relating to FIT and compliance with guidance is routinely shared with PCNs and is a focus for the Facilitators. PCNs are being encouraged and supported to include measures to increase compliance and record this in their action plans</p>
Locally-agreed tumour site	<p>Breast – As above for bowel, the Facilitators are working with PCNs and the locality screening leads to progress measures to increasing uptake of the screening programme. In addition, Facilitators are promoting the use of resources and initiatives for use by PCNs and their member practices to support self-examination and have provided links to education and training resources for all GP staff</p>
Other delivery updates	<p>The Primary Care and Early Diagnosis Facilitators are working across GM with all PCNs on the development and delivery of action plans in support of improving referral practice with specific reference to priority tumour sites. PCNs are being encouraged, in the development of their plans, to consider and utilise the resources and tools that have been developed by the Alliance and that are also available elsewhere. Think Cancer – clinical decision support tool has been refreshed and includes reference to priority tumour sites. Algorithms developed for gynae pathways and uploaded on to primary care systems.</p> <p>Summaries of performance and monitoring data for their PCN and member practices has also been supplied by the Facilitators to each PCN. Engagement has been good and there is an expectation that the vast majority of PCNs will return an action plan by the deadline – end July. In previous years over 80% of PCNs have returned an action plan and the hope is that this proportion will increase this year. The Facilitators will continue to support PCNs on the delivery of their plans and based on the content of plans returned a support program delivered with GP Excellence will be mobilised in Q2.</p> <p>Ongoing programme of primary care facing GM-specific education in the form of a series of ‘focus on’ videos. Completed for skin and lung.</p>

Q2	Lung	Work is ongoing in relation to Targeted Lung Health Checks and this is referenced elsewhere. As referenced below the Primary Care and Early Diagnosis Facilitators are supporting PCNs to include activity relating to this tumour site and when doing so to review the available data and engage with available resources and tools and the active promotion of patient and public awareness. Development of the Think Cancer – clinical decision support tool continues and now includes the identification of high risk patients (including those with persistent symptoms following a chest x-ray and 2+ courses of antibiotic in last 12 months for respiratory infections) to support onward referral. The tool also links to other resources for both patients and the public.
	Bowel	The Facilitators, as part of the development of action planning with PCNs have made available to them monitoring data relating to this tumour site and are working with the locality screening leads to progress measures to increasing uptake of the screening programme. In addition, monitoring data relating to FIT and compliance with guidance is routinely shared with PCNs and is a focus for the Facilitators. PCNs are being encouraged and supported to include measures to increase compliance and record this in their action plans
	Locally-agreed tumour site	Breast – As above for bowel, the Facilitators are working with PCNs and the locality screening leads to progress measures to increasing uptake of the screening programme. In addition, Facilitators are promoting the use of resources and initiatives for use by PCNs and their member practices to support regular self-examination and have provided links to education and training resources for all GP staff.
	Other delivery updates	<p>To support the delivery of the requirements of the PCN Early Cancer Diagnosis DES, PCNs across GM received a planning template earlier in the year. The completion of the template has been supported by the team of Early Diagnosis Primary Care Facilitators from the early diagnosis team at the Alliance. All PCNs have been actively engaged by the Facilitators in the development of their plans and the vast majority (64 out of 65 PCNs) have returned a completed plan and where they are outstanding assurances have been provided that plans will be completed and returned by the end of Q2.</p> <p>The content and ambitions outlined by PCNs has been fed back to localities to provide assurance that activity is ongoing to realise the requirements of the DES and to guide the ongoing support that can be provided by the Facilitators and other key stakeholders.</p> <p>This support relates directly to the ask of PCNs and includes, for example, accessing and interpreting practice activity data, guidance and tools relating to quality improvement planning and delivery, and bespoke training and education sessions relating to specific tumour sites.</p> <p>Based on an assessment of the plans provided, areas that require further development have been identified and the Facilitators will be working with PCNs to focus on, for example: standardising practice patient management systems (including safety netting); audits (including reviewing emergency presentations) and identifying and</p>

		<p>engaging groups under-represented in terms of suspected cancer referrals and specifically as they relate to priority tumour sites.</p> <p>As part of their routine engagement with PCNs to review progress against the submitted plans, the Facilitators will also be promoting and assessing the use of resources available via GatewayC and the Cancer Academy and tools such as the Clinical Decision Support Tool – ‘Think Cancer’ following its recent refresh and loading on GP clinical systems across GM.</p> <p>Furthermore, to support the work of the Cancer Alliance in relation to key objectives of the early diagnosis programme of work and that of the workforce and training and personalised care programmes, expressions of interest have been circulated across GM to GPs, Practice Nurses and Practice Manager colleagues with the intention of establishing of a pool of support roles that will provide professional and clinical expertise to both the Cancer Alliance, PCNs and their member practices.</p> <p>The Cancer Alliance team provide regular updates to the GM system primary care groups.</p>
Q3	Lung	<p>Work is ongoing in relation to TLHC and this is referenced elsewhere. Education and training materials have been refreshed and the Clinical Lead for the Lung Pathway has recently presented to PCNs. Support continues with PCNs via the Primary Care and Early Diagnosis Facilitator programme of work and this includes linking in with training and education programmes and efforts are being specifically targeted in those areas where presentation is below expectation. Refinements have been made to the Think Cancer – clinical decision support tool which has been loaded onto clinical systems and now includes the identification patients with multiple presentations and those at a higher risk (including those whose with persistent symptoms following a chest x-ray and 2+ courses of antibiotic in last 12 months for respiratory infections) to support onward referral. Safety netting procedures are also being updated in the tool following feedback. Training on the application of the tool is planned for Q4. The tool also links to other resources for both patients and the public.</p>
	Bowel	<p>The Facilitators, as part of the development of action planning with PCNs have made available to them monitoring data relating to this tumour site and are working with the locality screening leads to progress measures to increasing uptake of the screening programme focusing on localities and PCNs where this is low. In addition, monitoring data relating to FIT and compliance with guidance is routinely shared with PCNs and is a focus for the Facilitators. Training / workshop sessions with the lead consultants for this pathway have been designed for PCNs and will be delivered in Q4 in selected localities and following review may be rolled out across all localities. PCNs are being encouraged and supported to include measures to increase compliance and record this in their action plans</p>

	Locally-agreed tumour site	Breast – As above for bowel, work is being progressed with PCNs and the locality screening leads to progress measures to increasing uptake of the screening programme. In addition, the use of resources and initiatives for use by PCNs and their member practices to support regular self-examination have been provided together with links to education and training resources for all GP staff.
	Other delivery updates	<p>Planning templates relating to the delivery of the PCN Early Cancer Diagnosis DES have been returned to the Cancer Alliance by <u>all</u> 65 PCNs in Greater Manchester. The content and ambitions outlined in these plans and the output of the most recent round of visits by the Primary Care and Early Diagnosis Facilitators with PCNs to review progress has been utilised to guide the offer of the Facilitators and has been fed back to localities to provide assurance that activity is ongoing to realise the requirements of the DES. As stated previously, support from the Facilitators relates directly to the ask of the PCNs and in this quarter work has focused on the delivery of bespoke training for clusters of PCNs within localities to address education and training gaps. These sessions will be delivered in Q4. Alongside this programme of work the Facilitators continue to promote all education and training opportunities provided by both GatewayC and the Cancer Academy.</p> <p>The annual review of the GM suspected Cancer referral forms has concluded, and they will be loaded onto GP systems early in Q4 and will be linked to the GM Clinical Decision Support Tool ‘Think Cancer’ which has been updated following feedback from users.</p> <p>As outlined previously, a pool of support roles has now been established and is made up of GPs, a Practice Nurse and a Practice Manager who will provide professional and clinical expertise to both the Cancer Alliance, PCNs and their member practices. This group will be providing input to the work of the Alliance as part of the planning for 2025/26 in Q4 and will support the delivery of the plan going forward.</p> <p>As part of continuous efforts to improve referral quality the Alliance has begun work to audit a selection of primary care referrals for head and neck cancers with input from GP, dental and secondary care colleagues to identify education and training opportunities. It is anticipated that this approach will be used for other pathways and will be supported by the group outlined above.</p> <p>The Cancer Alliance Early Diagnosis team provide regular updates to the GM system primary care groups.</p> <p>The Cancer Alliance continue to release monthly PCN bulletins and hold monthly PCN Cancer Lead briefing sessions.</p>
Q4	Lung	
	Bowel	

	Locally-agreed tumour site	
	Other delivery updates	

Health Inequalities updates *(Please provide a brief update with regards to plans to address Health Inequalities as part of this work. Alliances should focus on how they are supporting PCNs to focus on communities of high deprivation in their geography.)*

Q1	Monitoring and performance data relating to the priority tumour sites has been provided to PCNs and this has included reference to deprivation and ethnicity. PCNs are being supported to utilise this information to support their planning and initiatives that they take forward to address health inequalities and to identify specific measures that they might undertake.
Q2	Where PCNs have made specific reference to health inequalities within their action plans, as referenced above, the Early Diagnosis Primary Care Facilitators are supporting the delivery of interventions to address identified inequalities and this includes supporting links to other system partners for example, screening and comms. Where reference is missing, or inadequate, feedback has been provided by the Facilitators and suggestions made. This will be monitored going forward and updates to actions plans will be reviewed in early Q3.
Q3	The Facilitators continue to support the work of PCNs and their member practices as outlined above and specifically this quarter are supporting the establishment of communities of practice where a focus on inequalities is being encouraged together with sharing good practice within and between PCNs. The Facilitators are also linking with PCNs where work is being delivered by the Cancer Alliance in relation to addressing inequalities (including case-finding and outreach).
Q4	

Risks *(Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)*

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) Engagement with PCNs has been good, the vast majority are engaged with the Early Diagnosis and Primary Care Facilitators who are supporting PCNs with the delivery of their action plans. The plans of a small proportion of PCNs need development as they lack insufficient				

detail. These PCNs are being prioritised by the Facilitators. Communities of practice are weak or do not exist for some PCNs and this is also a focus of the Facilitators to support their establishment.

Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter)

Each PCN has a dedicated Cancer Lead and the Facilitators together with locality leads and now the additional support roles are working hard to support them and their PCNs. Where PCNs are struggling to deliver plans, additional input is being provided. PCNs are being incentivised to develop and deliver plans and this, together with the support offered, is providing beneficial. The volume of contacts by PCN representatives with the Facilitators has continued to increase over the quarter reflecting an increasing understanding of the role of the Facilitators and the offer.

4.5 Innovation

Deliverable	<ul style="list-style-type: none"> Identify, fund, support, evaluate and share learnings from early diagnosis initiatives with a particular focus on the tumour sites with the highest volume of late-stage diagnoses in your area and deprived groups with lower rates of early diagnosis.
Success measures	<ul style="list-style-type: none"> <i>Alliances should set own metrics for initiatives.</i>

Narrative quarterly updates (*Cancer Alliances should report which strand of the early diagnosis strategy their initiative(s) contributes to and whether they are supporting any Innovation Open Call projects or tumour site review recommendations. Please also highlight any evidence you have gathered on the impact of these initiatives.*)

Q1	<p>7 priority pathways identified for early cancer diagnosis. Standard data set developed using RCRD to benchmark GM Cancer Alliance and show variation across GM. Used in locality and pathway board meetings to inform development of pathway specific early cancer diagnosis projects. Standing agenda item on ALL pathway boards 2024-25.</p> <p>Review of 2023-24 projects continues via the Early Diagnosis Programme Board.</p> <p>Work has commenced with Edge Health to develop a GM Early Cancer Diagnosis Strategy 2024-28. Extensive NHS GM ICB support and input.</p> <p>Lung 'Healthbot' ready to launch</p> <p>Task & Finish groups for early cancer diagnosis in place for lower GI / colorectal and lung pathway boards.</p>
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	<p>Projects in development for launch October 2024 – mobile community outreach projects for upper GI (capsule sponge testing in the community) and bowel cancer awareness (screening and symptomatic). Taking learning from the prostate cancer case finding project. Will focus on geographical areas of high incidence, high risk and low early stage diagnosis.</p> <p>CRUK CAM project progressing well in GM</p>
Q2	<p>The Cancer Alliance commissioned Edge Health to work with us on a strategy for early cancer diagnosis. This is a GM system wide strategy which has been developed with a significant number and range of stakeholders from across GM. The strategy is near completion and will be available in Q3. This will include detail of a range of initiatives to address the GM position against the 75% Long Term Plan ambition and includes a specific section on innovation.</p> <p>CRUK CAM results for GM released in mid-September 2024 and being used to inform the programme of work going forward, via the Early Diagnosis Programme Board, the Health Inequalities Programme Board and via the work on the GM Strategy.</p> <p>The Pathway Boards for the 7 priority pathways each have a work plan in place to address the current position with early diagnosis. Each pathway board meeting includes a standing agenda item and detailed presentation to outline progress to date and gain support for new initiatives.</p> <p>The Lower GI, Upper GI and Gynae Pathway Boards are each working on mobile community outreach projects, with the lower GI project due to go live in early Q3.</p> <p>The Cancer Alliance BI team have produced a dashboard that's available across GM which shows the Rapid Cancer Registration Data at a locality level. This will transform our ability to work with our locality colleagues and address areas of variation in early diagnosis. This data is forming part of the agenda for the NHS GM ICB 'Locality Assurance Meetings' in Q3.</p> <p>Evaluation nearing completion of the Innovation projects funded in 2024-25 and areas of good practice and potential spread identified.</p> <p>Lung Healthbot to launch 16th November 2024.</p>
Q3	<p>Tracking the GM position using the RCRD we have seen a gradual improvement in the staging data for GM during 2024-25, including 'closing the gap' between GM and the England average position.</p> <p>The Cancer Alliance commissioned Edge Health to work with us on a strategy for early cancer diagnosis. This is a GM system wide strategy which has been developed with a significant number and range of stakeholders from across GM. The strategy was presented to and approved by the Early Diagnosis Programme Board in December 2024 and will be presented to the GM Cancer Board and wider GM system (including locality boards) in Q4. As outlined in Q2, the strategy includes detail of a range of initiatives to address the GM position against the 75% Long Term Plan ambition and includes a specific section on innovation.</p> <p>CRUK CAM results for GM released in mid-September 2024 have been used to inform the programme of work going forward, via the Early Diagnosis Programme Board, the Health Inequalities Programme Board and via the work on the GM Strategy.</p> <p>The Pathway Boards for the 7 priority pathways each have a work plan in place to address the current position with early diagnosis. 6 of these pathway boards now have a named clinical lead on the board for Early Diagnosis.</p> <p>The Lower GI, Upper GI and Gynae Pathway Boards are each working on mobile community outreach projects - the lower GI project went live in November 2024. Ovarian project scheduled to go live March 2025.</p>

	<p>The Cancer Alliance have developed a clear plan for the delivery of mobile community based capsule sponge testing for Barret's Oesophagus. Plans are well developed, including primary care data searches to identify patients to be invited and a clear route to ensure coverage in the areas where there is highest reported incidence of the risk factors for Barret's.</p> <p>Early Cancer Diagnosis has been the spotlight in all 10 NHS GM ICB 'Locality Assurance Meetings' in Q3, enabling senior level discussions with locality / place representatives on their locality position against the 75% ambition and any plans in place to address this.</p> <p>LungAware Healthbot successfully launched 4th November 2024. Within the first month: 421 visits to the page; 151 interactions with the bot. Evaluation ongoing and learning to be taken to determine whether this model is transferrable to other pathways / tumour sites.</p>
Q4	



Risks (Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) Constant attention required to maintain profile and momentum				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) Early Diagnosis Strategy development, system wide engagement and reporting and the constant presence in pathway board meetings will maintain the profile and momentum. Strengthening relationship with Health Innovation Manchester. Recruitment in progress for an Innovation Project Manager – aiming to complete recruitment Q4.				


4.6 Health Inequalities

Deliverable	<ul style="list-style-type: none"> Cancer Alliance to develop, resource and deliver a clear workplan to ensure rates of early diagnosis improve in the most deprived areas by at least as much as in the least deprived areas. Cancer Alliances to use data resources and apply a Core20PLUS5 lens (i.e. looking at deprivation, protected characteristics and inclusion health groups) to embed health inequalities approaches across all programmes of work
Success measures	<ul style="list-style-type: none"> Early diagnosis gap by deprivation <i>Cancer Alliances should set their own metrics to measure progress towards addressing health inequalities in their area.</i>

Narrative quarterly updates (Please outline progress against each activity set out in the 24/25 delivery plan. Where progress has not been made, please provide details on barriers faced or other mitigating factors.)

Q1	<p>We have held two Talk Cancer Training the Presenter workshops and two online workshops. Planning has started for a F2F workshop in each locality.</p> <p>In Q1 we completed our Round 2 grants fund, awarding 10 projects grants totalling £49,869. Report attached.</p>  <p>Round 2 report.pdf</p> <p>Planning has started for our round 3 grants programme, which will launch in Q2 and issue £100k in grants to the VCSE sector to address inequalities in Early Diagnosis.</p> <p>The NDRS row level dataset was made available to the Cancer Alliance in Q1. Work has started on understanding how this data can be used to greater understand early diagnosis in our Core20Plus population.</p> <p>In Q1 we have started the review of our EIA process.</p>
Q2	<p>We have held a Talk Cancer Training the Presenter workshop and two online workshops. We have also held 3 locality F2F workshops which have targeted specific groups as identified by local intelligence.</p> <p>Round 3 of the VCSE grants project was launch in Q2, more info can be found here:</p>  <p>Cancer-Inequalities -Round-3-Guidance</p> <p>Q2 saw the completion of both the GM Cancer Alliance Early Diagnosis Insights report and the CRUK local Cancer Awareness pilot. Both of these reports will feed in to and insight and intelligence driven action plan to tackle health inequalities.</p> <p>Our BI team now has the NDRS row level data in a form that will allow us to analyse Early diagnosis by a number of demographics, including but not limited to:</p> <ul style="list-style-type: none"> • % Early-stage diagnosis, by locality • % Early-stage diagnosis, by IMD • % Early-stage diagnosis, by ethnicity • % Early-stage diagnosis, by age • % Early-stage diagnosis, by route to diagnosis • Distribution of early-stage cancer diagnoses by age • Incidence of late-stage diagnosis (map)

Q3	<p>Round 2 of our VCSE grant programme was delivered and concluded in Q3, with the impact report expected in Q4. Q3 also saw the awarding of round 3 of our VCSE grants programme where we awarded over £85k to 4 organisations. The 4 projects are summed up below:</p> <ul style="list-style-type: none"> • The first project with SAWN (Support and Action for Women's Network) will work with health inclusion groups in Oldham to support the early diagnosis of cancer. They will deliver culturally relevant information tailored to the Black African community via a women's group and choir. This will mean they will creatively use songs/role-play / sketches and podcast sessions. Their podcasts will be designed to be accessible and relatable and will feature discussions with experts, survivors, and advocates who will share their lived experiences and knowledge about cancer. It will feature a diverse range of speakers, including medical professionals, community leaders, and those with personal experiences, which will provide a broad perspective that appeals to a wide audience. • The second project will be a collaboration of Can Survive with Partners of Prisoners (POPS), an independent charity which supports individuals and families affected by a relative's involvement in the justice system. They will work with men and women from prisons in GM (health inclusion groups) to deliver focus groups and training programmes on signs/ symptoms of cancer. In addition to this they will train prison staff and pastoral teams to continue conversations. Furthermore, cancer champions recruited will support the longevity of the messaging. • The third project is an awareness campaign aimed at the older male population of Bolton. BWITC (Bolton Wanderers in the Community) plan to utilise the stadium as a community based drop-in clinic with support from local health care professionals. They will use their fan base to promote comms messaging. It will also include engagement activities such as stadium tours and using ex-players to appeal to and encourage the target community. They will have healthcare professionals via Bolton GP Federation on hand to offer health checks / screening conversations. • Our fourth project is with Wonderfully made woman, a well established organisation that works with women from Black, Asian and minority communities. Their plan is to collaborate with women from these communities in around 30 churches, 4 mosques, and other trusted spaces where they receive support and guidance. They will utilise Faith leaders and community champions to play critical roles in facilitating discussions, helping to overcome cultural barriers, and normalising conversations about cancer. Recognising that many women in these communities respond strongly to faith leaders, they will use this culturally appropriate approach to maximise engagement. They will also work closely with healthcare providers linking them with local GP surgeries. <p>The VCSE Cancer and Inequalities Network has now expanded to 46 organisations, with good attendance at the meetings and a very engaged group of organisations all happy to collaborate. The network includes peer sharing amongst the organisations and focuses on a wide range of cancer topics. As a group they are regularly utilised in providing feedback for NHS developed assets such as; the personalised care video assets, PPIE recruitment assts and comms resources. There is a recognition by GM Cancer Alliance of the importance of including this expert VCFSE voice in their plans and workstreams which can be seen by the constant guest visits of staff doing studies, events and creating assets.</p>
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	<p>We have delivered 3 CRUK Talk Cancer sessions; an online workshop, a Train the presenter workshop and a locality led F2F workshop, training 50 different individuals.</p> <p>We have produced a plan following on from the GM Cancer Alliance Early Diagnosis Insights report and the CRUK local Cancer Awareness Measure+ pilot (attached below). This work and plan have fed into the development of the Early Diagnosis Strategy and action from this plan will feed into the programmes of work that develop as part of the strategy work.</p>  <p>Insights Report and CRUK Local CAM Pla</p> <p>We have delivered 2 inequality training session, adapted from the Cheshire and Merseyside 123 Approach Training to the wider healthcare system and an internal EIA training.</p> <p>Our BI team have continued to test uses of the NDRS row level data. We now have a test dashboard where we can examine cancer diagnosis, both incidence and early diagnosis by:</p> <ul style="list-style-type: none"> • Sex • IMD Quintile • Age • Ethnicity • Locality <p>We also have a test dashboard for survival by demographics, but this is still in an experimental phase.</p> <p>We have also tested our ability to map late-stage diagnosis and target intervention to those areas, planning for the Lower GI and Gynae awareness have both used this methodology to inform areas they are targeting.</p>
Q4	

Risks *(Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)*

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
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Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) VCSE Cancer and Inequalities Network – there is a constant need to ensure that the organisation the voluntarily attend this network continue to find it useful and rewarding. Health Inequalities Data - there is a risk that the dashboards that have been produced stay in a test format unless we can assure the data that has been produced				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) VCSE Cancer and Inequalities Network – continue to review agenda and protect time for networking, sharing good practise and raising awareness of opportunities. Health Inequalities Data - Work with the wider system including our population health intelligence team to support us introduction of the health inequities datasets.				

5 Workstream: Treatment and Care

5.1 Treatment Variation

Deliverable	<ul style="list-style-type: none"> • Alliances to implement national priority recommendations from clinical GIRFT lung report to reduce variation in treatment. • Alliances to implement national priority recommendations from clinical audit reports to reduce variation in treatment: <ul style="list-style-type: none"> ○ Breast: Reduce reoperation rates after breast conservation surgery, whilst supporting safe breast conservation ○ Prostate: >75% of men receiving radical treatment for high-risk/locally advanced prostate cancer ○ Bowel: >50% patients receiving adjuvant chemotherapy after major resection for stage III colon cancer ○ Oesophago-gastric (OG): Reduce the number of patients with OG cancer waiting more than 62 days from referral to curative treatment, by identifying and implementing quality improvement interventions to improve speed and efficiency of treatment planning and delivery • Complete a bi-annual evaluation of demand and capacity of SACT services - Bi-annually evaluate the demand and capacity of SACT services across the Alliance footprint and identify what factors may lead to delivery issues
Success measures	<ul style="list-style-type: none"> • Link to all lung GIRFT metrics can be found here. Alliances are only to report against the 3 metrics which they have already selected. • Number of men with high/risk locally advanced prostate cancer not undergoing radical treatment within 12 months of diagnosis against agreed trajectory (TBC, plans for data to be provided nationally by NDRS) • Number of re-operations in women after breast conserving surgery (available via Model Hospital) against agreed trajectory • Number of stage III colon cancer patients not receiving adjuvant chemotherapy following major resection (TBC, plans for data to be provided nationally by NDRS) • Median days OG patients wait from referral to curative treatment (data to be provided by the National Team via CWT data)

Narrative quarterly updates: *(Cancer Alliances should provide information on what the benchmark of variation in each of the recommendations is. Please outline detail of any implementation or action plans that are in place and any progress against deliverables. Plans should include which clinical groups (ERGs, CRGs, CAGs, pathway boards) will be engaged to secure clinical leadership for this work to shape any planned quality improvement. Plans should include any hypotheses for why variation exists, and how Alliances will reduce this variation. SACT reporting should*

provide headlines from the demand and capacity assessments, if there are challenges in the Alliance footprint and what actions are being taken to address them. For the breast recommendation please use the [quarterly reported trust level metrics on Model Health System](#) to facilitate discussions with trusts to understand where unwarranted variation might be occurring.)

Q1	Treatment Variation Working Group	Lung Recommendation 1 [9 – Curative intent treatment rate NSCLC]	One stop treatment clinic for high-risk patients (now named CTOC), including the expanded offer for adjuvant and neo-adjuvant treatments remains in place with monthly operational group in place to continue to assess outputs. Partnership working has been agreed with AZ to support formal health economic evaluation of the service, with this being used as a first test bed in the SDE. Local audit continues to show curative intent treatment for this cohort up to 94% (from 80%)
		Lung Recommendation 2 [15 – Multi-modality treatment]	Expansion of the CTOC and pre-hab service for patients with lung cancer. Evaluation of the additional pre-hab to assess sustainability options is currently underway
		Lung Recommendation 3 [14 – Adjuvant and neo-adjuvant pathways]	Expansion of the CTOC and pre-hab service for patients with lung cancer. Evaluation of the additional pre-hab to assess sustainability options is currently underway
		Breast	Re-excision rates in model hospital do not suggest GM has outliers, however, a further, standardised audit is agreed with all trusts. Action plan to be determined post audit.
		Prostate	GM are currently under the 75% target at 63%. Audit agreed and data collection will be completed by end July which will outline the reason for all patients not offered curative intent treatment in this cohort. Row level data is being collected at GM level to allow health inequality assessment. All IG completed, test data currently being put through AGEM. Action plan to be determined post audit and is expected to include MDT and specific Trust actions. Meeting undertaken in June with agreement in principle to progressing with replicating the lung CTOC model, which for lung saw curative intent treatment moving from 80% to 94% in local audit as a key intervention to improve curative treatment rates in high risk patients. A formal proposal will go to the Q2 clinical pathway board and a working group established thereafter. Further work is expected to come out of the audit.
		Bowel	GM has positive adjuvant treatment rates and is not an outlier overall based on latest national data and feedback from the MDTs is positive on the process of post surgery assessment of patients for adjuvant therapy. Latest data has been shared with the clinical pathway board. Adjuvant treatment is expected to include post-surgery MDT formalisation. Action included within the MDT reform work, with the first meeting July 24.

	OG	<p>There are five key actions agreed to support improved time from referral to curative intent treatment. Milestone wait data based on treatment modality is now in place.</p> <p>Complete pathway re-design is underway, from diagnostic bundles and local provision, through to revised MDT working, and prompt management of patients – through CTOC provision. Potential go-live September 24 subject to estate and capital being allocated. Meeting to confirm is planned with the DoS for July 24.</p> <p>Diagnostic bundles re-design has progressed and a draft standard is currently out for consultation between teams.</p> <p>MDT reform plans are progressing well, with changes in principle now being defined into a working model.</p> <p>Roll out of the CTOC (as per the model used in lung) is progressing well. Potential go-live September 24 subject to estate and capital being allocated. Meeting to confirm planned for July 24.</p> <p>A clinical lead has been appointed to bring on the last EUS site to SQD project, to create a full GM service, maximising utilisation of assets and reducing variation. (underpinned with a GM capacity and demand exercise) Expected to go live Q2. Work with PET also continues, although the go-live in Q3 is likely to be delayed.</p> <p>Radiotherapy pathway improvement, as part of the cross-cutting work project.</p>
Overall Updates and SACT	Overall Updates	<p>The work programme will create the first true GM audit, with the ability to assess row level patient data and understand true determinants of variation, including deprivation, ethnicity. This detailed work and complex IG work and amendments to schedule 6 contracts paves a road map for a clinical effectiveness style approach to cancer at system level.</p> <p>The CTOC model is now being considered for other areas – such as pancreatic, based on the outputs seen in Lung (1 year survival 10% improvement etc). A paper will be submitted for publication in Q2. The cancer alliance will also present this model at the Q2 national treatment variation work meeting.</p>

		SACT	Three meetings have been undertaken with the pharma company MSD. Their model is activity and demand, rather than true capacity and demand. Feedback to national team has resulted in a possible opportunity for this model to be developed further. Utilisation of this model is being considered, but as it will not deliver true capacity and demand an alternative option is being considered. A meeting scheduled for the end of July with all key stakeholders is expected to determine the model to be used and data collection definitions will be agreed and data collection commenced.
Q2	Treatment Variation Working Group	Lung Recommendation 1 [please enter]	One stop treatment clinic for high-risk patients (now named CTOC), including the expanded offer for adjuvant and neo-adjuvant treatments remains in place with monthly operational group in place to continue to assess outputs. Partnership working has been agreed with AZ to support formal health economic evaluation of the service, with this being used as a first test bed in the SDE. Full pathway mapping has now been completed to support this work.
		Lung Recommendation 2 [please enter]	Expansion of the CTOC and pre-hab service for patients with lung cancer. Evaluation of the additional pre-hab to assess sustainability options remains ongoing CTOC operational impact evaluated and publication submitted with BMJ
		Lung Recommendation 3 [please enter]	Expansion of the CTOC and pre-hab service for patients with lung cancer. Evaluation of the additional pre-hab to assess sustainability options remains ongoing CTOC operational impact evaluated and publication submitted with BMJ
		Breast	Although it is not felt that any of the sites are outliers in relation to re-excision rates, a prospective audit is currently underway, based on the updated clinical guidelines. Data collection will be analysed at GM level
		Prostate	Although data is available nationally, this is somewhat outdated, and does not tell us about the decision making process or any issues regarding trends. Therefore, GM is undertaking the first GM full system audit (containing patient row level information). This data will be pseudonymised and linked to wider databases in GM to enable a granular review against deprivation, age cohorts etc. All IG is completed and data has now been uploaded to AGEM to test transfer and joining to other datasets
		Bowel	A comprehensive review has been undertaken and presented by the clinical team in the Colorectal Pathway Board. The review determined that no further action was needed. The full clinical findings can be provided. This was supported by the Pathway Board. Review of adjuvant treatment will remain a priority for the MDT meetings and through the MDT reform work that is currently ongoing
		OG	New diagnostic bundles and an MDT model are now designed. The OG one stop is prepared for go-live pending estate issue resolution. These are the actions designed to improve the time to curative intent treatment

	Overall Updates and SACT	Overall Updates	The CTOC model is planned for further roll out (prostate and HPB). Airelogic have been commissioned to deliver two GM wide audits as a further testbed for the ongoing focus on treatment variation
		SACT	Work has commenced with The Christie in terms of a local model for capacity and demand, and evaluation of an internal activity and capacity model
Q3	Treatment Variation Working Group	Lung Recommendation 1 [9 – Curative intent treatment rate NSCLC]	One stop treatment clinic for high-risk patients (now named CTOC), including the expanded offer for adjuvant and neo-adjuvant treatments remains in place with monthly operational group in place to continue to assess outputs. Partnership working is in place with AZ to support formal health economic evaluation of the service, with this being used as a first test bed in the SDE. Governance for direct access to the SDE has been completed. A cost analysis has been completed in the interim whilst the full health economics work continues which shows favourable results.
		Lung Recommendation 2 [15 – Multi-modality treatment]	Expansion of the CTOC and pre-hab service for patients with lung cancer. Evaluation of the additional pre-hab to improve uptake of SACT in palliative patients and for multi modality treatments is complete with positive outcomes. Further data is awaited and a proposal to continue whilst greater data on survival and treatment rates is awaited. This was supported by the TV Programme Board CTOC operational impact evaluated and publication submitted with BMJ
		Lung Recommendation 3 [14 – Adjuvant and neo-adjuvant pathways]	As above
		Breast	Although it is not felt that any of the sites are outliers in relation to re-excision rates, a prospective audit is currently underway, based on the updated clinical guidelines. Data collection will be analysed at GM level
		Prostate	As previously reported GM is undertaking the first GM full system audit (containing patient row level information). This data will be pseudonymised and linked to wider databases in GM to enable a granular review against deprivation, age cohorts etc. Remaining Trusts awaiting upload. Analysis will then be completed, and action plan agreed. New project manager in place to drive this forward.
		Bowel	As per Q2
		OG	CTOC clinic go live now end Q3. MDT and diagnostic bundles in place to support rapid pathway improvement
		Overall Updates	Focussed work on creating audit tool for wider use in place

	Overall Updates and SACT	SACT	First draft of Christie solid tumour analysis complete and presented to SACT board. Final feedback awaited before wider circulation.
Q4	Treatment Variation Working Group	Lung Recommendation 1 [please enter]	
		Lung Recommendation 2 [please enter]	
		Lung Recommendation 3 [please enter]	
		Breast	
		Prostate	
		Bowel	
		OG	
	Overall Updates and SACT	Overall Updates	
		SACT	

Updates against quarterly milestones *(Use this space to confirm if progress is in line with milestones set in the 24/25 Alliance plan, and if/why any need to change.)*

Q1	<p>All actions maintained from 23/24. Ongoing evaluation of the CTOC (Cancer treatment and optimisation clinic) in place and long term case for change being developed including in-depth health economic evaluation., assess efficacy and develop sustainability case.</p> <p>For Breast, the local audit has moved to September for data collection, in line with the updated national audit so the latest metrics are being used for analysis. IG / DPIA processes are currently under way. This will factor in variation in delivery – screening centres, complex DIEP etc. Action plan to be determined post audit</p>
Q2	Actions are all progressing related to TV with positive progress on sustainable improvements and methods for audit at GM level
Q3	As per Q2
Q4	

Risks (Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) 1) Estate to deliver CTOC model of care and workforce headcount limitations (OG now resolved, but for expansion plans) 2) Sustainability funding of CTOC model of care in light on the ongoing significant financial challenge in GM 3) Pace of change – although a small number of action some of these within this work programme require wholesale system change and significant engagement				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) 1) Engagement with the Trust DoS. EMD support for this model of work. 2) Detailed HE evaluation 3) Ongoing programme management and engagement. Regular reporting, maintaining momentum				

5.2 Living With and Beyond Cancer

Deliverable	<p>Set up local agreements that fully establish core personalised care interventions and Personalised Stratified Follow Up (PSFU), in line with NHS-wide guidance, within local commissioning and/or provider monitoring arrangements.</p> <p>Based on the Alliance's existing knowledge and/or on new gap analyses, co-produce improvement plans and agreements for sustainable commissioning and delivery of: a) prehabilitation interventions/services in line with guidance from the national team; and b) the offer of brief behaviour change and other intervention(s) across the whole cancer pathway that support people to increase any form of physical activity.)</p>
Success measures	<ul style="list-style-type: none"> Proportion of trusts that have PSFU protocols operational, split by breast, prostate, colorectal & endometrial.

Narrative quarterly updates *(For Local Agreements, please provide narrative of progress towards reaching local agreements e.g. stakeholders involved, what format the local agreement is expected to take, what is being included, when agreement(s) are expected to be finalised.*

For COSD data submission, please provide update on maximising data quality in COSD version 10 for HNA/PCSP, EOTS and physical activity assessment. Please name any trust that is not submitting data to COSD. For PSFU, please report by exception - please name any trusts that are not yet operational with PSFU with their expected go live dates and any reason for unexpected delays. For psychosocial support, prehabilitation and physical activity please include an update, as appropriate, on service continuity where service developments have been funded short-term)

Q1	Local Agreements	<p>GM KPI Personalised Care document updated for 24/25 – reviewed and approved by ? on ?</p> <p>Continuous feedback sought from Lead Cancer Nurses and Trust Personalised Care Leads on usefulness and accuracy of KPIs to ensure they will support service improvement.</p> <p>Discussing addition of personalised care deliverables to the NHS GM contracts with providers in GM to raise profile and importance of standardised delivery and performance management. Supported by Alliance ?</p> <p>Qualitative evaluation proposal being presented at GM System Cancer Board end of July 2024 to request approval of this approach to evaluating the value of a dRMS (infoflex) in supporting delivery of PSFU given challenges with long term funding of this system for GM.</p>
	COSD data submission	<p>All Trusts except for MFT and Christie including personalised care data as standard as part of their COSD submission.</p> <p>MFT – Trust wide challenges with EPIC reporting correct data sets as part of the COSD submission continues. Personalised Care data has been flagged as important but the issue is much wider. Manual data is being recorded across CNS teams so we are assured personalised care interventions are being offered and numbers are increasing.</p>

		<p>Christie – plans continue to include personalised care within COSD submission (previous timeline assured this would be completed in July 2024). Recently notified that the internal Trust roadmap for the wider COSD submission refresh did not include treatment summary data. Trust Personalised Care lead escalated with newly appointed Chief Nurse (Vicky Sharples) to agree how this data will be integrated.</p> <p>Sessions with Pathway CNS subgroups to present and review our GM Personalised Care dashboard has identified continuing concerns with visibility of accurate levels of data via the nationally recognised dataset (COSD) which informs our dashboard. Working with NCA Personalised Care Lead and Paul Stacey to do a deep dive into the performance of some teams to understand if it is an inputting error or COSD isn't reporting it correctly on the dashboard.</p>					
PSFU – Breast, Prostate, Colorectal, Endometrial		Digital Remote Monitoring System	Breast PSFU	Colorectal PSFU	Prostate PSFU	Endometrial PSFU	
	Salford (NCA)	Fully implemented	N/A	Fully operational	Fully operational	Fully operational	
	Bury, Rochdale and Oldham (NCA)	Fully implemented	N/A	Fully operational	N/A	Fully operational	
	Tameside	Fully implemented	Fully operational	Not operational	Training completed but have only stratified a very small number of patients	Training completed – stratifying small numbers	
	Wrightington, Wigan and Leigh	Fully implemented	Fully operational	Training completed – stratifying small numbers	N/A	Fully operational	

		Stockport	Fully implemented	N/A	Training completed – stratifying small numbers	Training completed – stratifying small numbers	Fully operational	
		Bolton	In testing stage	Fully operational using spreadsheet	Not operational	N/A	Fully operational using spreadsheet	
		The Christie	In testing stage	N/A	Not operational	Fully operational using spreadsheet	N/A	
		MFT	Use Hive to track but will share data with the rest of GM via Infoflex	Fully operational	Fully operational	N/A	Fully operational	
		<p>Progress continues to be made towards full implementation of PSFU in 4 main pathways as well as developing PSFU pathways for additional tumour groups to be built on the dRMS (Infoflex). Engagement supported by continued ‘launch events’ at Trusts and training being delivered by our GM Infoflex System Manager to CNS teams to increase confidence in the system.</p> <p>Feedback from CNS teams has been limitations in the workforce, lack of CCCs or navigators to support PSFU tracking, is impacting ability to fully implement PSFU in some pathways. Encouraging Trusts to share successful business cases for cancer support staff.</p>						
Psychosocial support	<p>Meeting held with GMMH 30th April – Plans initiated to move ahead with collaborative project. MOU shared with GMMH and they will advance to sign off with their Care Group and then Strategic Delivery Group (dates to be confirmed but indicated at end July). Programme Manager (strategic overview) role for this workstream (and genomics) advertised with interviews scheduled for 19th July and Project Manager (project delivery) role for interviews scheduled for 31st July.</p> <p>Delivery began of 2 innovation funded projects by the Cancer Alliance:</p>							

		<p>Project 1 – Pilot three innovative support options for children with an oncology diagnosis, their parent/carers and siblings. Parent ‘café’ support groups for parents/carers adjusting to their child’s oncology diagnosis. (up to 9 groups). Tree of Life (ToL) group for children and young people who have finished active treatment (‘ringing the bell’) and are adjusting back into day-to-day routines and a ‘new normal’. (up to 4 groups). Forest School support programme to enable siblings to address the adverse psychological impact of having a brother or sister with a cancer diagnosis. (up to 4 groups) project to be delivered through 2024/25 and currently running to time as set out in PID.</p> <p>Project 2 - Expansion of the service to offer Eye Movement Desensitisation and Reprocessing Therapy (EMDR), Interpersonal Therapy (IPT) and Acceptance and Commitment Therapy (ACT) to people with Cancer within Tameside. Funding agreed and processed but not initiated.</p>
	Prehabilitation	<p>Mapping/ scoping initiated including:</p> <ul style="list-style-type: none"> • Collation of known Prehab4Cancer services • Cross reference of Prehab offers with those identified through previous HWB survey responses and LWwC stakeholder events already held (namely Tameside, Rochdale, Bury, Oldham). This will continue in line with the LWwC mapping engagement work into Q3. <p>Requested clarity from national team on operational definitions of activity levels (specialist, targeted and universal) to inform a more useful mapping template.</p>
	Physical activity	<p>Mapping/ scoping initiated including:</p> <ul style="list-style-type: none"> • Collation of known physical Activity offers at locality level, focusing on interventions provided by level 4 physical activity professionals. • Cross reference of physical activity offers with those identified through previous HWB survey responses and LWwC stakeholder events already held (namely Tameside, Rochdale, Bury, Oldham). This will continue in line with the LWwC mapping engagement work into Q3. <p>Requested access to and integration of the Physical Activity Assessment data collected via COSD into our Personalised Care dashboard to understand current practices in relation to identifying patients who do not achieve guidance level of physical activity. BI team escalated with Paul Stacey who is looking into this.</p>
Q2	Local Agreements	<p>GM Personalised Care Service specification drafted – includes delivery of HNAs, PCSPs, EoTS and PSFU. This will be added as contract variation to the ICB performance contract with GM Trusts – approach was approved by ICB Cancer System Board in September. The draft specification is being presented at the GM Lead Cancer Nurse forum 9/10 for input and agreement on process for Trust internal monitoring approach.</p> <p>No data reporting burden for Trusts as HNA, PCSP and EoTS data will be available via our GM Personalised Care dashboard based on our GM Personalised Care KPIs to monitor improvement in performance. Working on</p>

		<p>developing a data submission template to support an automated monthly upload of PSFU data from infoflex into the dashboard so all personalised care data is available from a central location.</p> <p>The data reporting requirements within the service specification will encourage Trusts to be checking they are inputting and submitting personalised care data accurately via COSD as well as utilise infoflex for the delivery of PSFU as this is what will provide them with their performance data that will be required to monitor compliance with the service specification.</p>																					
	COSD data submission	<p>290 people attended webinars on the importance of recording personalised care data and how to do this, so it is reported accurately via COSD (6 sessions)</p> <p>60 people attended webinar on how to use the GM personalised care dashboard (2 sessions)</p> <p>MFT update - started submitting data but it has not been backloaded currently so unable to see a full data set until the end of Q2. There is no data coming through for KPI2 'Percentage of individuals that are offered a Holistic Needs Assessment having one completed'. After investigating this is most likely an error with how the data is submitted rather than not being completed. Paul Stacey is investigating with the Trust.</p> <p>Christie update - Head of Analytics confirmed they are still on track to start submitting COSD v10 in November as per the revised NHS England deadline. This submission (for September data) will include HNA data. Once the data starts flowing we will work with the Christie on how to improve the data capture.</p>																					
	PSFU Breast, Prostate, Colorectal, Endometrial	<p>Position as of 1st October 2024</p> <p>Greyed out cells indicate that the provider does not operate a PSFU service for that disease group:</p> <table border="1"> <thead> <tr> <th></th><th>Digital Remote Monitoring System</th><th>Breast PSFU</th><th>Colorectal PSFU</th><th>Prostate PSFU</th><th>Endometrial PSFU</th></tr> </thead> <tbody> <tr> <td>Salford (NCA)</td><td>Fully implemented</td><td></td><td>Fully operational</td><td>Fully operational</td><td>Fully operational</td></tr> <tr> <td>Bury, Rochdale and Oldham (NCA)</td><td>Fully implemented</td><td></td><td>Fully operational</td><td></td><td>Fully operational</td></tr> </tbody> </table>					Digital Remote Monitoring System	Breast PSFU	Colorectal PSFU	Prostate PSFU	Endometrial PSFU	Salford (NCA)	Fully implemented		Fully operational	Fully operational	Fully operational	Bury, Rochdale and Oldham (NCA)	Fully implemented		Fully operational		Fully operational
	Digital Remote Monitoring System	Breast PSFU	Colorectal PSFU	Prostate PSFU	Endometrial PSFU																		
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Bury, Rochdale and Oldham (NCA)	Fully implemented		Fully operational		Fully operational																		


		Tameside	Fully implemented	Fully operational	Training booked for November	Training completed – stratifying small numbers	Fully operational
		Wrightington, Wigan and Leigh	Fully implemented	Fully operational	Fully operational		Fully operational
		Stockport	Fully implemented		Training completed – stratifying small numbers	Training completed – stratifying small numbers	Fully operational
		Bolton	Fully implemented	Fully operational using spreadsheet	Not operational		Fully operational using spreadsheet
		The Christie	In final stages of implementation		Not operational	Fully operational using spreadsheet	
		MFT	Use Hive to track but will share data with the rest of GM via Infoflex	Fully operational	Fully operational		Fully operational
		<p>Colorectal PSFU update: The Christie - will not fully implement colorectal PSFU until they have Infoflex as they do not feel it is clinically safe to do it without a secure system.</p> <p>Bolton – Training has been pushed to November at the Trust’s request and will start to fully stratify using infoflex in Q4.</p>					

		GM confirmed we will be completing the PSFU and EOTS snapshot data collection request shared by the National LWBC team.
	Psychosocial support	<p>Programme Manager started in post 2/9 Psychological Support/Personalised Care Manager started in post 16/9 who will be delivering the joint 'Think Well' project in conjunction with one of our Mental Health Trusts (GMMH).</p> <p>'Think Well' Project update:</p> <ul style="list-style-type: none"> • Approved MoU between Alliance and GMMH • Finance transfer arrangements agreed • Clinical roles commenced to TRAC (recruitment system) by GMMH for recruitment 26/9 • Alliance Psych Clinical Lead to be part of interview panel on behalf of the Cancer Alliance <p>Psych Delivery Group 25/9 – update and governance on projects plus subject matter expertise offered on several other educational projects i.e. Supporting psychosexual needs of patients as carers project, update of psych level 2 modules, animation scripts. Work up of primary care education package signed off at Delivery Group to be initiated in November.</p> <p>Delivery began of 2 innovation funded projects by the Cancer Alliance: Project 1 – Pilot three innovative support options for children with an oncology diagnosis, their parent/carers and siblings currently running to time as set out in PID and interim report released. Project 2 - Expansion of the service to offer Eye Movement Desensitisation and Reprocessing Therapy (EMDR), Interpersonal Therapy (IPT) and Acceptance and Commitment Therapy (ACT) to people with Cancer within Tameside. Funding transacted, project initiated and first tranche of training to begin in November. Update provided to Psych Delivery Group 25/9 with full backing and support received.</p>
	Prehabilitation	<p>Mapping/ scoping continues:</p> <ul style="list-style-type: none"> • Based on feedback from stakeholders we have simplified the template previously shared by the LWBC National team – for prehab this will include services offered by acute care • Plan to cross reference Prehab offers via GM Pathway Boards to check whether there is any tumour specific prehab offers • ORCHA – focused work to identify prehab apps available for patients postponed until Q3 • Prehab4Cancer team provided training session on how to use ORCHA as a professional to refer patients to appropriate apps available via our GM platform

	Physical activity	<p>Mapping/ scoping continues:</p> <ul style="list-style-type: none"> • Based on feedback from stakeholders we have simplified the template previously shared by the LWBC National team – for physical activity this will include services/offers available by referral from acute care and available in the community (by locality), educational/behavioural changes resources available • Cross reference of physical activity offers with those identified through LWwC stakeholder events continues. Completed for Tameside, Oldham, Bury, Bolton and Salford. Progressing currently with Manchester (North, Central and South). • Collating physical activity/behavioural change education offers currently available with plans to align to ACCEND framework and make available via our Personalised Care page on the GM Cancer Academy • ORCHA - focused work to identify physical activity/behavioural change apps available for patients postponed until Q3
Q3	Local Agreements	<p>GM Personalised Care Service Specification going through consultation with key stakeholder groups – mainly being co-developed with the GM Lead Cancer Nurses as they will be included as the Provider Leads responsible for delivery of Specification. This will be included as a contract variation and reportable for 25/26 therefore will be included within wider GM contracts review in final quarter of 24/25.</p> <p>Regularly reviewing the GM Personalised Care dashboard from a data quality perspective and our BI team are responding to Trust feedback to update as needed. The Alliance are attending tumour specific CNS forums to showcase the dashboard and how it can be used. Plans in Q4 to develop Trust specific views of the dashboard in curator broken down by tumour group for Trust LCNs to utilise when the service specification is in affect as part of the Trust monitoring arrangements.</p>
	COSD data submission	<p>The Christie – Update from the Head of Analytics is that currently The Christie Data Engineering and Analytics team are re-building their Trust COSD v10 submission which will incorporate basic HNA assessment data (ie was one offered, the status, and the point of the patient pathway it was offered). This will be for patients with an event in September 2024 onwards. They are still ironing out some issues with the v10 build (currently on round 3 of testing) and working with NHS England to get this correct. Once the format of the submission has been approved by NHS England, we will resubmit our COSD from September data onwards. Currently they are continuing to submit in v9 which does not contain HNA data.</p> <p>MFT – continued challenges with COSD data across MFT with HIVE. Some personalised care data is pulling through into the dashboard, but it is incomplete. Numbers are being monitored manually internally by the Trust Personalised Care lead. Issues have been escalated and incidented appropriately via the MFT digital team who are meeting weekly to resolve the ongoing challenges.</p>

	<p>PSFU Breast, Prostate, Colorectal, Endometrial</p>	<p>Colorectal PSFU: Tameside – training for dRMS booked for CNS team mid Jan to be fully operational by the end of Jan 2025 Bolton – Trust reported they are focusing on fully implementing one pathway at a time rather than concurrently therefore they have paused any progress with operationalising colorectal. This has been escalated and the Alliance have offered support with ensuring all steps required prior to utilising the dRMS have been actioned and have requested a meeting to include our MD in Q4 with the Trust LCN, digital project manager and Trust Cancer Lead. Christie –The clinical team have advised around 25% of patients will be eligible for the existing GM high risk PSFU pathway used by all other teams but they also require 2 additional high risk plus pathways due to the complexities of their patients. Ready for full operationalisation for the 25% when the dRMS is available as they have a local protocol developed (waiting final clinical approval at Pathway Board) and final funding decision for additional CCC required due for approval in Q4.</p> <p>Prostate PSFU: Tameside – training for dRMS booked for CNS team mid Jan to be fully operational by the end of Jan 2025 Stockport – GM Prostate PSFU pathway re-designed which has limited PSFU to only Prostatectomy patients that have had their surgery at Stockport will be stratified by Stockport (all others will be followed up at the Christie). Therefore the CNS and admin team are working through identifying these patients which are all currently booked into general clinics before manually uploaded to the dRMS (infoflex). Meeting with the Trust in January to agree action plan and if there is any additional support the Alliance can offer to ensure the GM agreed pathway for Prostate is fully operational.</p> <p>Key challenge – strategic and executive buy in re; importance of prioritising operationalisation of PSFU and ongoing financial position of ICB is impacting on agreement for ongoing funding of the dRMS which an evaluation has shown is required to deliver PSFU a clinical safe way.</p>
	<p>Psychosocial support</p>	<p>'Think Well' Project update – GMs improvement plan: MOU signed off and recruitment to the clinical posts commenced. The Band 8b post was successfully appointed with a start date in Q4, the band 8a post was not successfully recruited to. After round 1 and options appraisal for contingency was approved by the Personalised Care Team and GMMH and after an unsuccessful 2nd round of advertising the post description has been adjusted to allow for counselling therapists to be included for selection, which will be a more attractive proposition and aim to attract more candidates. Programme manager and Project Manager have been in post since September and are moving the projects forwards. The GMMH project is at initiation stage with a joint PID being used as the working document for the</p>

	<p>project. Discussions have taken place with the GMMH data team with alliance data representation to request a data dashboard to track the service performance and uptake. The service IT system can then be put into place to ensure that any additional data points can be added to the information capture forms as that aspect of the service is put together. Hopefully these operational aspects of the service can be put into place to expedite the commencement of the service to counteract the delays to recruitment.</p> <p>Innovation Projects – funded by Personalised Care Programme after a dragon’s den style EOI submission process to support smaller scale projects:</p> <ul style="list-style-type: none"> • Project 1 - Update provided in September delivery group, including finance update. The groups are up and running with 2 Tree of Life, 2 woodland adventures and 3 parent cafes delivered to the end of September. Interim reporting has been produced with detailed feedback on the activities delivered. Recruitment for the next round of groups, strategy meetings and working groups for each arm were the focus for Q3. • Project 2 - Provided updates in September and December delivery groups. Expedited access for IPT, ACT and EMDR is now operational. Further expansion to the EMDR team is in progress along with a research assistant. There have been some delays to CFT training, however assurances were provided that these delays will not prevent progression of these roles and training being undertaken but will impact timescales. All training places will be in place at project end date. <p>Psychology Support & Delivery Group:</p> <p>As part of the HWB animation series a sex/intimacy animation is in progress. In creating a generic animation it became apparent that this would not cover all groups. Additionally, the theme was raised separately at the December PPIE coffee and cake meeting. December's delivery group was approached for consensus on support for an extended series and stakeholders have been canvassed for themes to support a series of 5/6 animations (e.g. Tumour group specific, relationship specific, sexuality specific resources). The education team requested AI training ideas and it was suggested that the 2 are linked with the animations raising awareness and a similar themed AI package is produced to train staff to deal with enquiries linked to the animations.</p>
Prehabilitation	<ul style="list-style-type: none"> • Mapping/ scoping completed (may need additional resource added in line with LWWC mapping) • Co-production of agenda for GM LWWC final event on 7th March session planned to discuss findings of mapping of Prehab/rehab/physical activity • Summary of findings by service and locality presented to Alliance Programme Assurance Board for information and review – agreed with next steps to develop a LWWC phase 2 plan which will focus on the development of a Live Well with Cancer model for GM (links with the ICB Live Well Programme).

		<ul style="list-style-type: none"> Drafted proposed LWWC model including prehab/rehab/PA for ICB/GMCA consideration – this will inform the co-production of an improvement plan utilising gaps and themes identified from the prehab/rehab/PA mapping. <p>Please see attached high level summary of findings:</p>  <p>16.10.24 Prehab.Rehab.PA Sum</p>
	Physical activity	<ul style="list-style-type: none"> Mapping/ scoping completed (may need additional resource added in line with LWWC mapping) Co-production of agenda for GM LWWC final event on 7th March session planned to discuss findings of mapping of Prehab/rehab/physical activity. Summary of findings by service and locality presented to Alliance Programme Assurance Board for information and review – agreed with next steps to develop a LWWC phase 2 plan which will focus on the development and Live Well with Cancer model for GM (links with the ICB Live Well Programme). Drafted proposed LWWC model including prehab/rehab/PA for ICB/GMCA consideration – this will inform the co-production of an improvement plan utilising gaps and themes identified from the prehab/rehab/PA mapping. Physical Activity Assessment data collected via COSD – National team current position is that this may not be possible to obtain. Collation of ORCHA apps to support prehab/rehab under headings Building Strength – 4 apps and Staying Active – 5 apps Exploring options with Alliance Primary Care Medical Director how we can embed simplistic messaging within primary care appointments pre-diagnosis on importance of keeping active
Q4	Local Agreements	
	COSD data submission	
	PSFU Breast, Prostate, Colorectal, Endometrial	
	Psychosocial support	
	Prehabilitation	
	Physical activity	

Risks (Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter (Briefly explain the risk to delivery – overwrite each quarter) <ul style="list-style-type: none"> Continued delays to technical go live of infoflex to support delivery of PSFU will impact benefits realisation of full implementation Continued challenges with varying levels of Cancer Support Workers (CCCs and Navigators) and lack of support internally within Trusts to fund additional roles impacts delivery of all personalised care interventions. 				
Risk Mitigation for the quarter (Briefly explain how you are mitigating/will mitigate the risk, or support needs you have – overwrite each quarter) <ul style="list-style-type: none"> Requesting assurance from MFT and Christie regularly on their digital plans to ensure personalised care data reporting as part of COSD submissions Providing project management resource to oversee and manage the technical implementation of infoflex with each Trust GM System Cancer Board (November 2024) approved the evaluation findings and supported 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 				

5.3 Experience of Care

Deliverable	<ul style="list-style-type: none"> Encourage and ensure Trusts/System partners use insight and feedback (including CPES/U16 CPES) to understand how people are experiencing cancer services and identify and implement what service improvements could be made, taking into consideration health inequalities.
Success measures	<ul style="list-style-type: none"> <i>Cancer Alliances should set their own metrics to measure improvement of experience of cancer care.</i>

Narrative quarterly updates *(Please ensure to address only the deliverable related to Experience of Care, rather than anything that relates to the People and Community deliverable as this should be covered in [section 1.3](#))*

Q1	<ul style="list-style-type: none"> • Programme Director presented in May 2024 the GM CPES data to the Personalised Care Board. Recognised that while we were above the national average for experience of care related to personalised care we still need to continually improve. Board recognised the challenge in utilising CPES results within some Trusts as it is hard to drill down and therefore encouraged the importance of Trusts utilising their own experience of care surveys and results as well. • The MFT Trust Personalised Care Lead shared with the Board how MFT use CPES and their internal Trust patient experience surveys to inform service improvements. • The GM Personalised Care Clinical Lead drafted specific experience of care questions to be incorporated into existing trust EoC surveys that will provide Trust Lead Cancer Nurses and CNS groups with more useful feedback on the quality of the personalised care interventions being offered. Shared with LCNs for feedback in June. <p>Live Well with Cancer (LWwC):</p> <ul style="list-style-type: none"> • In response to the 2021 mayoral manifesto commitment the LWwC programme has been progressing with producing a clear pathway by locality so that someone newly diagnosed with cancer can find out about what support is available to address their health and wellbeing needs. <ul style="list-style-type: none"> ○ Utilising a place-based approach across all 10 boroughs and working with partners across the health and social care system including the VCSE and user led/community organisations to help reduce health inequalities. • Tameside, Oldham and Bury complete, Bolton and Salford progressing throughout July and August. Manchester to be divided into x3 (North, Central and South). <ul style="list-style-type: none"> ○ Tameside CNS has now set up a community eHNA clinic because of this mapping as she identified a gap and linked with a library which had space for clinics at the steering group. • Each locality we have held x3 steering groups bringing together all relevant stakeholders across that locality to map the current and identify areas for improvement in the personalised care pathway (from diagnosis to EoL) and access to relevant services and support. A final face to face meeting is then held to agree the localities LWwC pathway. <p>ORCHA</p> <ul style="list-style-type: none"> • Designed and co-developed the GM ORCHA website with patients – patient apps have been collated and grouped to address the most popular concerns raised by GM patients utilising HNA and QoL survey results. • Go live delayed due to restrictions of pre-election period – postponed to July which will be supported by 6 training sessions for staff on how to utilise the platform as a ‘social prescribing’ tool.
Q2	Personalised Care Experience of Care questions

- Current CPES questions do not support ability to identify the experience of personalised care interventions for patients
- Questions co-developed with Trust Personalised Care Leads and approved at GM Personalised Care Board in September. Clinical Lead to work with each Trust on how they plan to share questionnaire (include within current experience of care questionnaires or as an ad hoc collection).
- Plan to request access to results as an Alliance to analyse responses across GM and identify themes to inform improvement plans.

Live Well with Cancer (LWwC) locality mapping:

- Salford – First draft report produced and comments received 2nd draft sent to stakeholders for final comments by mid-October
- Manchester split into 3 North, central and South – individual steering groups competed and joint final f2f event booked 4/10
- Trafford - planning and set up through October
- Stockport - planning to commence end October
- Each locality mapping exercise will result in a bespoke report detailing the discoveries made when we worked with key stakeholders to scope out what it would take to build a 'Live Well with Cancer' and resulting in a directory of personalised care services/interventions for that locality throughout each step of the pathway:
 - Point of referral – access to social prescribing teams
 - Booking appointment – access to P4C offer, Macmillan Cancer Information and Support Services, offer of HNAs
 - Treatment – Cancer Care Map
 - End of treatment – treatment summary letters
 - Follow up - PSFU
 - Wider H&WB support – list of community-based services available for that locality

ORCHA

- ORCHA site launched on 9th July
- Comms campaign planning commenced to start on socials through Oct. Digital literacy work started paused due to staff sickness
- Over 10 training session delivered with 119 invited users (professionals) and 53 have activated their accounts. Trainer the trainer session at Peterloo surgery Middleton
- Audit of apps on site commenced due to changes in status of many i.e. funded by some localities not others, apps now void, apps not updated in last 12 months etc

Cancer Improvement Collaborative project

- GM Alliance submitted a project to CIC and was successful - the project is proposing to develop a template based on the ethos of current end of treatment summary template but tailored to metastatic patients. It will be a document to support both a patient's

	<p>future physical health and current, and future mental wellbeing by acting as a reference point for the patient to keep referring to over several years.</p> <ul style="list-style-type: none"> • Project team established including 2 patients with lived experience. Had 1 on-line session with national team and one f2f in London. First steering group 16/10
Q3	<p>CPES promotion:</p> <ul style="list-style-type: none"> • National toolkit shared with GM Lead Cancer Nurses – highlighted resources available. • Alliance comms team shared via our PPIE Cancer Voices newsletter plus via the alliance social media channels. <p>DSPA106 Sharing of NCPES free text – National request</p> <ul style="list-style-type: none"> • PPIE Manager shared request with Christie IG lead for information – feedback received on what we would be required for a DSA that would support this. • National team confirmed they would be developed a DSA that we can use locally. <p>Personalised Care Experience of Care questions</p> <ul style="list-style-type: none"> • Co-developed Personalised Care EoC questions approved at Personalised Care Board and available for all Lead Cancer Nurses to utilise. • The Alliance Personalised Care Clinical Lead meeting with LCNs regularly to have oversight of how each Trust is planning to distribute these questions – requires internal IG approval whether they are going to be included within existing surveys or as a one off. • Requested access to the response data gathered from these questions as the Alliance to review and identify areas for improved – approved. • Depending on approval of Trust plans to implement a process to share and collate responses for these EoC questions we should have some initial response data to review in Q4. <p>Cancer Improvement Collaborative project update:</p> <ul style="list-style-type: none"> • Met with Comms Lead and CNSs to discuss patient voice video • Met with Clinical Oncology Colorectal Consultant to discuss comms on chemo wards and peripheral clinics • Met with CNS reps to discuss issues around reoccurrence and start to map out where gaps are • Discussing raising staff awareness of living with a long-term chronic condition with workforce and education team • Idea sharing with WWL Innovation Project regarding Metastatic Patients and use of their patient findings from their innovation project (Alliance funded).
Q4	

Risks (Please document programme-level risks to achieving the deliverables. At each quarter, please overwrite the Risk description and Mitigation as relevant, or make it clear if the same risk remains from last quarter)

Start of year RAG (add risk rating from plan)	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Risk Description for the quarter – no risk				
Risk Mitigation for the quarter – N/A				

6. Local Projects and Exiting Programmes

You can use this section to provide updates on any local projects or exiting programmes (Capsule-sponge, CCE, Lynch or NSS) that you wish to include, but are not required to report on. Ensure to include the title of the project or programme that you are updating on.

Q1	NSS – sustainability of the NSS pathway is now resolved. Referrals through NSS continue to be above the 3% target.
Q2	Lynch – funding for 2025/26 not yet agreed. Paper is being submitted to ICB, pending expected costs from MFT.
Q3	Lynch & NSS – included in GM ICB commissioning intentions for 2025-6
Q4	

