GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Greater Manchester Cancer Board

Agenda

Meeting time and date: 8.00am-10am Friday 9th March 2018

Venue: Frank Rifkin lecture theatre, Mayo Building, SRFT.

Chair: Richard Preece.

#	Item	Type	To	Lead	Time
1	Welcome and apologies	Verbal	-	Richard Preece	5′
2	Minutes of the last meeting	Paper 1	Approve	Richard Preece	
3	Action log and matters arising	Paper 2	Note	Richard Preece	
4	Update from GM Cancer User Involvement Steering Group	Verbal	Note	Sarah Haworth Nabila Farooq Ian Clayton	15′
5	Lung Cancer update: ▪ Optimal Lung Cancer Pathway ▪ CURE: secondary Care smoking prevention programme	presentations	Note	Matt Evison	30’
6	Single Surgery Services in Cancer: Implementation Programme Update	Paper 3 presentation	Note	Sarah Maynard-Walker and Kate Rogerson	15’
7	Recovery Package Implementation update	Paper 4 Presentation	Note	Wendy Makin/ Lindsey Wilby	20’
8	GM Cancer Commissioning update	Presentation	Approve	Adrian Hackney	15’
9	Process for Cancer Programmes accessing the GM Cancer fund	Paper 5	Discuss	David Shackley	15’
10	AOB				
11	Future Meeting Dates: ▪ **4th May 2018:** 8-10am ▪ **13th July 2018:** 8-10am ▪ **7th September 2018:** 8-10am				

Work Plan and agenda Items GM Cancer board 2018:

GM Cancer Board meetings		Standing Agenda Item	Work programme
4th May 2018	Humphrey Booth Lecture Theatre SRFT 8-10am	▪ User involvement update ▪ Cancer Plan programme update ▪ 62 day update	▪ Psychological Support pathway Board: update ▪ Screening Action Plan update ▪ Acute Oncology commissioning specification ▪ OG Cancer best practice pathway update
13th July 2018	Frank Rifkin Lecture Theatre SRFT 8-10am	▪ User involvement update ▪ GM Cancer Plan programme update ▪ 62 day update	▪ Systemic Anti-Cancer Treatment strategy ▪ Lung Health Checks update ▪ MDT reform in GM ▪ Cancer Workforce Strategy update
7th September 2018	Board Rooms 2&3 Trafford General 8-10am	▪ User involvement update GM ▪ Cancer Plan programme update ▪ 62 day update	▪ 100k Genomes update ▪ Genomics pathway board update ▪ End of life strategy and palliative care ▪ HPB pathway board update

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Paper number 1

Greater Manchester Cancer

Minutes of Greater Manchester Cancer Board

Time & date: **8.00am-9.30am Friday 9th Feb 2018**

Venue: **Humphrey Booth Lecture theatre, Mayo Building, SRFT.**

Chair: **Dr Richard Preece**

GM Health & Social Care Partnership Team		Richard Preece	RPre	Executive Lead for Quality, GMHSC Partnership (Chair)
AGG of CCGs		Rob Bellingham	RB	Managing Director, Association of GM CCGs
Provider Trusts	Salford	Emma McGuigan	JS	Senior Manager
	Manchester FT	Darren Banks	BD	Director of Strategy
	Stockport	Helen Thomson	HT	Interim Chief Executive
	The Christie	Fiona Noden	RS	Director of Operations
	Pennine Acute	Roger Prudham	RPRu	Deputy Medical Director
Person affected by Cancer		Nabilla Farooq	NF	
Person affected by Cancer		Ian Clayton	IC	
User Involvement GM Cancer		Sarah Howarth	SH	Macmillan User Involvement Programme Manager
Eastern Cheshire CCG		Sally Rogers	SR	Director of Quality
GM Population Health		Jane Pilkington	JP	Deputy Director Population Health
Medical Director GM Cancer		David Shackley	DS	Medical Director, Greater Manchester Cancer
Director of Commissioning – GM Cancer		Adrian Hackney	AH	Director of Commissioning – GM Cancer
Nursing Leadership		Dawn Pike	DP	Director of Nursing, MFT
Christie School on Oncology		Cathy Heaven	CH	Associate Director, Christie SoO
Cancer Education Manchester		Richard Cowan	RC	Chair, Cancer Education Manchester
Vanguard Innovation Programme		Jenny Scott	JSc	Programme Director, Greater Manchester Cancer Vanguard Innovation
VCSE group		Marcella Taylor (for Donna Miller)	MT	VCSE group representative

In attendance

Prostate Pathway presentation	Satish Maddineni	GB	Urology Pathway Director
62-day Presentation	Susi Penney	SP	Head and Neck Pathway Director
GM Cancer	Claire O'Rourke	COR	GM Cancer
GM Cancer	James Leighton,	JL	GM Cancer
GM Cancer	Michelle Leach	ML	GM Cancer
MFT	Ryan Donaghey	RD	Provider Federation Board
University of Manchester	Catherine Perry	CP	University of Manchester-RESPECT 21

1. **Welcome and apologies**

RPre welcomed all to the meeting and noted the apologies received. He then invited the participants to provide introductions.

2. **Minutes of the last meeting**

IC asked about the actions from the January meeting, with regard to commissioning, which were not on the agenda. RB confirmed this will be included in the March meeting.

3. **Action log and matters arising**

All actions are on today's agenda or are included in the board's work plan for future meetings.

4. **Update from GM Cancer User Involvement Steering Group**

IC spoke on behalf of the UI steering group and reported that they felt the tabled finance paper was not open or transparent and lacked clarity. On the assumption that the future transformation cancer funding was not sufficient to deliver the whole GM Cancer Plan 2017-2021, he asked what would not be delivered from the plan and how would such decisions be made including what degree of UI there would be in such decisions.

IC asked about uncertainties about future cancer *infrastructure* funding and specifically he asked for clarity on what impact this would have on the UI team and how this team was to be funded. He went onto explain that the users were meeting on the 10th February to agree the UI work plan for 2018/19 and the steering group felt that the lack of clarity on future funding was a significant risk to successful delivery of this.

RPre responded by emphasising that GM Cancer was planning to deliver all elements of the plan and that the overall cost was different to the funding request form the Transformation Fund.

He went onto say that he felt disappointed that users do not feel fully engaged and will review how better assurance can be provided to the group.

IC expressed the view that the level of engagement on finance issues and non-finance issues was significantly different. RPre agreed to attend the work plan meeting on Saturday.

5. **Greater Manchester Cancer: Vanguard Innovation evaluation**

JS presented the update and the proposed transition plan. She outlined the areas of work that had been undertaken, the user involvement and the key outputs from the Vanguard.

She confirmed that the national & local evaluation of the Vanguard will continue until 2020 to assess the long term benefits. She then provided her reflections on the work of the Vanguard in GM and went onto explain what the next steps would be for the work of the Vanguard.

RPre asked CH about the level of engagement of practice staff with Gateway C. CH explained that whilst the team had focused on GPs they had also engaged with the whole practice team. She acknowledged that the number of practice nurses registering on Gateway C was less than expected and so the team would work on this to increase the numbers in the future.

RPre advised that there was a new lead for practice nursing at the GM HSCP and she would be of benefit to achieve this.

JS reflected that the impact of the Vanguard was considerable with a lasting local and national legacy. Most of the clinical programmes were pilots and an assessment on the level and degree of future investment would need to be taken. DS acknowledged that there were three major pieces of work of national significance and these are Gateway C, best timed (or 'accelerated') pathways and the Communities of Practice national events. A strong relationship with the two major London cancer systems has also been established on the back of the Vanguard which will continue beyond March 2018.

JP noted the challenge of the Vanguard timescales and recognised that the difficulty of providing an output in just two years. RPru asked that the projects that were less successful should also be reviewed and the lessons learned. JS responded and confirmed that this would be happening.

DS discussed the benefit to the system of an innovation fund to encourage and drive forward new ideas in GM in the future. JS and SM responded with their experiences that innovation funded projects often remain as pilots and are not translated to broad system change. DS advocated a mixture of continual new ideas and mainstreaming of the most successful projects.

RPre thanked everyone for their contribution and encouraged all to continue to innovate and try new methods and practice.

6. 62-day cancer standard: final report

DS provided the background and spoke to the tabled paper outlining the methodology. He explained the themes and 12 core recommendations within the paper. He described the five emerging themes from this work:

1. Clinician engagement with delivery of the cancer waiting time standards
2. Best practice commissioning to support the standards
3. Pathway boards relationship with providers and cancer managers
4. Adopting GM standards on 62-days
5. Data sharing and digitisation

DS then invited SP to develop these further. She explained that successful delivery was dependant on greater collaboration and communication between organisations.

She confirmed that the report is about sharing good practice and bringing everyone up to the same standard for the benefit of our patients.

IC thanked the team and praised them for their work.

RPre asked who has agreed the recommendations and SP explained the actions were agreed by Trusts at the 2018 January meeting of the Trust Cancer leads (coordinated by GM Cancer). FN explained the role of the DoOPs and that they would be taking responsibility for measuring the outputs.

IC advised that documentation for the GM HSCP refers to meeting the 62-day standard whereas the GM Cancer Plan aims to be world class and there is therefore a disconnect between two

elements of the GM system in terms of ambition. SP responded that the work was indeed about all patients and all pathways achieving treatment within the timescales.

RC asked about resourcing improved clinical networking particularly in pathology and radiology. SP advised that it was more about working smarter rather than increasing investment. FN explained that this was a realistic possibility of future delivery as the radiology and pathology development programmes already existed and the technology could be put in place to provide this level of networking.

RPru expressed the view that the connectivity of GM was opportunistic and not really designed for purpose. RPre responded that a GM HSCP information strategy was being developed which he felt would achieve this.

FN emphasised that this work was about patients and not just about providers achieving the 62-day standard. DS concurred and explained, by way of example, that the lung pathway ambition in GM was a 28-day standard whilst nationally the future 2020 ambition is a 50-day standard.

IC spoke about the target to reduce avoidable deaths by 1300 over the lifetime of the plan and emphasised that we should strive to be world class and not just achieving 62-days. RPre responded and confirmed that GM HSCP was focussed on prevention, better outcomes and better treatment.

RPre thanked all for their work and asked FN to return with a report at a future meeting.

7. Resourcing the GM Cancer Plan and infrastructure

AH spoke to the report and explained that it remained a work in progress and that the process to finalise resources was continuing. He then explained that the nature of the bilateral locality meetings and their purpose.

He confirmed that the outcome was that there were sums of money available along with investment from Macmillan and CRUK. He then went on to outline the nature of this investment.

He explained that 75% of the funding for the core team was now available and for a two-year period but a shortfall in funding remained. He explained that the Macmillan money was planned to taper off and so a plan to carry on the work after this finishes was required.

With regard to the system funding, he explained that this work continues and all sources of funding and other opportunities to be able to continue this work were being explored.

IC put the funding of cancer in the context of the NHS 5-Year Forward View and the aims of the National Cancer Vanguard and asked how commissioning would work to achieve these outcomes. He explained his view that the GM commissioning strategy lacked significant input on cancer.

He went on to say that there was no reporting of patient involvement in commissioning. He explained that he held the opinion that the locality meetings should be directed from the top.

He questioned why the infrastructure remained not fully funded and stressed the risk to the team and the potential impact of this.

RB agreed that the robust challenge from users was helpful and that the GM Transformation Portfolio Board shows a continuing commitment to the work of the Cancer Board. He confirmed that the Board has got £10m from the Transformation Fund and that the CCG and provider funding for the next 2 years had been agreed.

RPre went onto correct the perception of ‘ring-fencing’ of the Transformation Fund e.g. for cancer. He confirmed that a significant proportion of this funding (totalling £450 million for GM over 5 years) had been allocated to localities with smaller proportion remaining at GM level and that devolution meant that no formal ‘ring-fencing’ of resource was appropriate – each call on funding had to be squared against other calls on transformation. He confirmed that it is not about

disinvesting from Cancer. RPre assured board members that cancer would get sufficient resource to deliver the outcomes that GM patients expect and need.

The board noted this report and RPre confirmed that this issue will come back to future meetings.

8. GM Cancer Annual Report

DS spoke to the paper and outlined the highlights in GM such as smoking and early diagnosis. He explained that it was now a finished document and asked for it to be approved and then published. RPre asked Board members to confirm their acceptance by 16th February.

9. Prostate Cancer 'Best Timed Pathway' Update

SM provided an update on the work of the Pathway Board on designing the Best Timed Prostate Pathway. He outlined the context of prostate cancer in GM and nationally and provided an overview of the new pathway and how it differs from the existing pathway.

RPre asked how the new pathway was going to be delivered across GM. SM responded that the imaging aspect was crucial to ensure implementation as the pathway is predicated on timely reporting of prostate MR scans, as the frontline diagnostic tool. This would be undertaken in collaboration with the urology single service implementation group.

FN explained that the urology implementation group was key is looking to deliver the prostate pathway earlier. RPre asked for clarity on when the timeline for this pathway would be in place. FN explained that the first diagnostic hub could be in place by May in the NE sector.

RPre thanked all for their contribution and agreed to add this to the work programme of the Board.

10. Any other business

(i) RC discussed the proposal of a GM cancer conference which is being planned for November 2018 and will be for approximately 300 delegates and will be fully sponsored.

(ii) RC also noted the contribution and engagement of the Users on and to the board and commended the UI group for developing this level of support.

11. Date of next meeting

9th March 2018: 8-10am

12. Future Meeting Dates (All 08:00 to 10:00hrs):

- **4th May 2018**
- **13th July 2018**
- **7th September 2018**

Greater Manchester Cancer Board

Action log

Prepared for the 9th March 2018 meeting of the board

	ACTION	AGREED ON	STATUS
1	Review of Greater Manchester's SACT strategy to be conducted, co-producing a refined strategy. Meeting to be convened with CCG teams and providers	3rd November 2017	SACT Strategy to be circulated to relevant groups update **July 2018**
3	Acute oncology: commissioning service specification to be completed	3rd November 2017	Update for Acute oncology and Paper for GM cancer board **May 2018**
4	MDT reform: DS to report back to GM cancer board in July on progress on pilots	3rd November 2017	Paper for GM cancer board **July 2018**
5	It was agreed and confirmed that there would be a commissioning update	9th February 2018	Confirmed this would be an agenda Item **9th March 2018**
6	JP to provide an action plan and update on the screening to the GM Cancer board in May 2018.	12th January 2018	Paper GM board **May 2018**
7	Progress report on Genomics Board to report back to the GM cancer board in September 2018.	12th January 2018	Paper GM board **September 2018**

Agenda Item No: 6

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	9/3/18	
Title of paper:	**Single Surgery Cancer Implementation Programme Update**	
Purpose of the paper:	The paper outlines the progress underway for the following Single Surgery Cancer Service programmes: a) Oesophago-gastric (OG) Cancer Surgery b) Urology Cancer Surgery c) Gynaecological Cancer Surgery	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	☐	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes **Improved patient experience** **Reducing inequality** **Minimising variation** **Operational / financial efficiency**	The implementation of the single surgery service models and associated specifications form part of the GM Health and Social Care transformation programme to standardise acute and specialised services (Theme 3). The aim of the single surgery service model is to address poor patient outcomes, improve patient access and experience; there will be single clinical leadership, governance and delivery arrangements put in place alongside standardised performance management arrangements.	
Author of paper and contact details	Name: Sarah Maynard-Walker & Kate Rogerson Title: Programme Director / Senior Project Manager Email: sarah.maynardwalker@nhs.net / kate.rogerson@nhs.net Tel: 0161 967 0300	

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Paper number 3

Date: 9 March 2018

Title: Single Surgery Cancer Implementation Programme Update

From: NHS Transformation Unit on behalf of the Health & Social Care Partnership

Purpose of paper

This paper outlines the progress underway for the following Single Surgery Cancer Service programmes:

d) Oesophago-gastric (OG) Cancer Surgery
e) Urology Cancer Surgery
f) Gynaecological Cancer Surgery

Recommendations

The GM Cancer Board is asked to note the content of this report, the progress made in each of the programmes and support the planned delivery of the milestones to achieve full implementation

Contact

Sarah Maynard Walker, Programme Director, NHS Transformation Unit
Sarah.maynardwalker@nhs.net

Kate Rogerson, Senior Project Manager, NHS Transformation Unit
kate.rogerson@nhs.net

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Single Surgery Cancer Implementation Programme Update

9 March 2018

1. Purpose of this document

The provision of cancer services in Greater Manchester has not been compliant with national standards for a number of years. In order to meet national standards, commissioners have worked collaboratively with GM Trusts and service users to design fit for future models of care and new service specifications.

This paper outlines the progress underway for the following Single Surgery Cancer Service programmes:

g) Oesophago-gastric (OG) Cancer Surgery
h) Urology Cancer Surgery
i) Gynaecological Cancer Surgery

2. Oesophago-gastric (OG) Cancer Surgery

In October 2016 commissioners wrote to each of the current providers, University Hospital of South Manchester NHS Foundation Trust (UHSM), Central Manchester University Hospitals NHS Foundation Trust (CMFT) and Salford Royal NHS Foundation Trust (SRFT) to confirm their intention to award the contract for provision of OG cancer surgery to one Trust, SRFT. The letters confirmed the importance of continuing to work together, involving clinicians from all three trusts, to complete the detailed design and implementation of the single centre of excellence.

The first implementation Board took place in March 2017 and monthly meetings have taken place thereafter. This board is supported by an Operational Working Group and a Clinical Sub Group, both meeting fortnightly.

Over the course of 2017, the following has been achieved:

- Project resources are in place and operational to support project delivery.
- The implementation plan is in place; it is a live document and continues to be refined with the input of stakeholders.
- The first patient has been successfully operated on at SRFT by Mr John Vickers and an MFT surgeon, Mr Simon Galloway.
- Research & Development trials continue to be very important and will remain intact to support the improvement of clinical outcomes; SRFT are proactively addressing capacity and registration issues.
- The clinical pathway has been designed and was signed off at the February Implementation Board.
- Amendments to the specification have been agreed following feedback from MFT. This prompted the development of a ‘specification change process’ agreed by SCOG in Nov 2017 (see appendix A).

The programme has been addressing a number of implementation issues relating to:

- The inter-dependency between the single on call rota for OG (to deliver the Specification requirements), the Healthier Together programme and the management of the recruitment gap for emergency general surgery.
- Agreement of a firm date to transfer the elective OG surgery cases from Wythenshawe Hospital to SRFT.

These issues were recently resolved and a weekly operational task and finish group is now in place to progress both the on call rota arrangements and the transfer of electives.

3. Urological Cancer services in Greater Manchester

In June 2017, the commissioners wrote to each of the current providers to advise of their decision to award Manchester Foundation Trust, Wythenshawe site, as the Lead Provider for the GM Urology Cancer Surgery Service and The Christie as the Key provider. The single operative provider for the prostate cancer surgical service will be The Christie NHS Foundation Trust and the combined single kidney and bladder operative service provider will be Manchester Foundation Trust, Wythenshawe site.

Clinicians from all sites will have a continuing role in developing the service through implementation of the new model and into the future to deliver high quality care close to home for the vast majority of cancer patients who do not undergo radical surgery.

Since June 2017, the following has been achieved:

- Urology Cancer Surgery Implementation Board established with first meeting held June 2017
- Governance structure for Urology Cancer Surgery Implementation agreed to include the formation of a Prostate Sub Group and a Kidney and Bladder Sub Group
- Lead and Key Provider Board established with first meeting held August 2017
- Clinical sub group established with first meeting held October 2017
- Clinical Lead appointed, November 2017
- Pathway Board drafted proposed prostate pathway in collaboration with: Royal Marsden Partners NHS FT, University College London NHS FT, GM Cancer User involvement programme
- Prostate cancer pathway draft agreed by Sub Group and presented to Implementation Board
- Pathway Board produced draft kidney and bladder pathway
- Impact of urology reconfiguration shared with GM uro-radiology group and uro-radiology representatives recruited to clinical Sub Group.

For the remaining quarter of 2017/18, the milestone plan from the Board and wider clinical and operational groups is as follows:

Milestone	**Delivery Date**
Early modelling of SMDT following visits to each site by Clinical lead	Jan – March 2018
Design of SMDT for each cancer pathway	Jan – March 2018
Establish task and finish group to consider on call rotas to include benign urology clinical lead/colleagues	Jan – March 2018
Initial analysis of operational data returned from each trust to inform phasing of implementation	Jan – March 2018
Prostate, Kidney & Bladder Pathways reviewed by Implementation Board	Feb 2018
Outline design of on-call rotas	*March 2018*
Confirm options for and agree phasing of implementation	*April 2018*
Once phasing agreed, complete full project plan	*May 2018*
Implementation of lead / key provider governance arrangements	*April 2018*
Development of Performance Management Framework	April 2018
**the following dates are provisional and may change following detailed design of phasing and implementation plan. Timescales will also be linked to implementation of other GM change programmes.*	
Transfer of first prostate cancer patients to The Christie	*April – June 2018*
Transfer of first bladder cancer patients	*April – June 2018*
Transfer of first renal cancer patients	*July – September 2018*
Begin implementation of on call rotas for all urology across GM	*July-Sept 2018*
Research opportunities and work towards establishing research strategy targets – maximise recruitment into clinical trials	2018/19
Skills Development Programme	2018/19
Improve access to template prostate biopsies to target	Sept 2018 onwards
Equal access to robotic renal surgery subject to business case and funding approval	Jan – March 2019

In addition the programme will address the following issues:

- Agree cross-trust patient pathways and referral protocols
- In-depth understanding of workforce implications
- Ensuring that the new service model reflects the agreed service specification
- Liaising with the benign urology programme to ensure that no other services or programmes of work are destabilised as a result of changes in urology cancer surgery services
- Agreeing and coordinating communications to all stakeholders, including providing regular communication bulletins via its members.

4. Gynaecological Cancer Surgery

The 'Gynaecology Cancer Service Recommendations to the Commissioner' report was full supported and endorsed by members of the Specialised Commissioning Oversight Group (SCOG) in September 2017. The report set out the clear objective of a "single service" for specialised gynaecological cancer diagnosis and treatment in Greater Manchester.

Gynaecological cancer surgery services in GM will be commissioned as a single service for patients who use Greater Manchester services, in order to improve outcomes, improving access, significantly develop the clinical services and research in gynecological cancer, so creating a virtuous cycle of research, service improvement and better outcomes, to ensure that they are always at the leading edge of cancer care in England and internationally.

MFT has been designated as the Lead Provider for the single GM Gynaecology Cancer Service and The Christie as the Key Provider.

The first Implementation Board took place on 15 Dec 2017 where the vision, key messages for the programme and clinical standards were agreed. A clinical sub group and implementation sub group will be established and all meetings will take place on a bi monthly basis.

In addition, the February board agreed the updated milestone delivery plan for the programme:

Milestone	**Delivery Date**
Implementation of single research strategy	Oct/Dec 2018
One Stop Diagnostic Clinics Phase 1 including gap analysis	June 2018
Skills Development Programme	Sept 2018
SMDT model	Oct/Dec 2018
Single IT support system design	Dec 2018
Specification, including: • Organisational structure & delivery arrangements • Performance management framework	Spring 2019

5. Respect 21 Project

Respect 21 is an independent study of how the changes to specialist cancer surgery have been carried out, whether anything might have been done better, and whether the changes have improved quality of care, patient experience, and patient outcomes. It is focusing on the centralisations of specialist surgical pathways for prostate, bladder, kidney, and oesophago-gastric cancers. It is hoped that the research will contribute to similar work in other specialist services.

This study is being carried out by researchers from University College London and the University of Manchester, in collaboration with stakeholders from London Cancer and Manchester Cancer. It is funded by the National Institute for Health Research Health Services and Delivery Research Programme (NIHR HS&DR).

The Respect 21 Research Fellow attends both the OG and Urology Cancer Surgery Programmes governance meetings and contributes to the research activities through e.g. interviews with stakeholders. Regular reports are also prepared and presented to the Respect 21 Steering Committee.

6. Recommendation

The GM Cancer Board is asked to note the content of this report, the progress made in each of the programmes and support the planned delivery of the milestones to achieve full implementation.

Appendix A

Specification Change Process

Agenda Item No: 7

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	9/3/18	
Title of paper:	**Recovery Package Implementation update**	
Purpose of the paper:	This paper outlines the progress underway in the implementation of the Recovery Package across GM and current challenges to delivery.	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	☐	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes **Improved patient experience** **Reducing inequality** **Minimising variation** **Operational / financial efficiency**	The Recovery Package is a combination of important interventions that, when delivered together, can greatly improve the outcomes and coordination of care for Cancer patients. It will lead to key improvements in the supportive care programme for Cancer patients, to reduce duplication of appointments and enhanced communication between care providers, from primary and secondary Care services.	
Author of paper and contact details	**Lindsey Wilby** Macmillan Project Manager – Living with and Beyond Cancer | **Greater Manchester Cancer** **Lindsey.Wilby@christie.nhs.uk** 0161 918 2185 | 07879 402915	

Greater Manchester Cancer Board

Paper number 4

Date: 9 March 2018

Title: Living with and Beyond Cancer: Recovery Package Implementation update

From: GM Cancer Recovery Package Project Office

Living with and Beyond Cancer: Implementation of the Recovery Package in GM

1. The Recovery Package as a Key Objective

Achieving World Class Cancer Outcomes: Taking Charge in Greater Manchester highlights the Recovery Package as one of GM Cancer's top six key priorities:

"We will ensure that the Recovery Package is available to all patients reaching completion of treatment by 2019. The Recovery Package is a combination of important interventions that, when delivered together, can greatly improve the outcomes and coordination of care".

The Recovery Package includes:

- Holistic needs assessments (HNA) leading to the production of care plans
- Treatment summaries
- A cancer care review (undertaken in primary care), and
- Offer of attendance at a health and wellbeing event.

2. Key targets and deadlines

The overarching objective to ensure that the Recovery Package is available to all patients by 2019 is broken down into several targets, with agreed timescales as follows:

Date	Target
August 2017	Standardised Greater Manchester approach to the Recovery Package agreed

December 2017	All patients receive a care plan at the point of diagnosis and treatment decision, and at the end of their treatment, based on holistic needs assessments (preferably eHNA)
March 2019	Full Recovery Package available to all patients reaching completion of treatment (including treatment summaries, cancer care reviews, and health and wellbeing events)

3. Challenges in achieving these targets

a) Prioritisation and engagement

Historically it has been challenging to persuade some professionals and organisations to see this area of work as a priority, even though it is an aspect of care which people affected by cancer place great value upon.

The introduction of the highly ambitious targets in the GM Cancer Plan have certainly been a driver for change, in that they have led to the implementation of the Recovery Package being recognised as a high priority across the region. This leverage has assisted us in overcoming some barriers to progress and we now have strong engagement throughout pathways, across Trusts, and with many secondary care professionals.

Further work is needed to establish clear pathways to meaningful engagement with colleagues in primary care. We would also value closer working relationships with commissioning colleagues to understand their intentions with regards to commissioning the elements of Recovery Package as part of standard care.

b) Resources

The Recovery Package targets are at risk due to the gaps in the resources available to deliver them, the most significant of these being the workforce needed to support the introduction of two detailed HNA/care planning conversations for each patient. We await the outcome of the GMHSCP funding bid, but for context the PID submitted for the Recovery Package included a request for Band 4 support staff (to free up CNSs to complete HNAs) which totalled £4.3 million over the next 3 years to March 2021. This is a genuine estimation of what we believe it would cost to deliver the 100% HNA target, and therefore any shortfall in this will impact upon our achievement of that target.

The PID also assumes that, in return for the above funding, Trust will need to reallocate some of their existing budgets to support the following:

- Invest in appropriate hardware (in the form of tablet computers or other devices) to enable Trusts to transition from paper-based HNA to eHNA, and provide IT support in signing up to eHNA and integrating it with other Trust systems.

- Develop their internal IT systems to allow staff to record their use of the elements of the Recovery Package with a minimum of cross-recording on multiple systems.

- Support staff (primarily nursing staff but may apply to others e.g. therapy radiographers) in re-evaluating their job plans to account for the significant proportion of their time that will be spent in conducting HNAs and producing and following up care plans.

- Support the recruitment of additional staff (included in funding request) to deliver this project, including providing HR support, Trust contracts, and computer access and office accommodation.

- Sign up to a cross-regional sharing agreement via the information governance portal, to allow the sharing of care plans generated via the eHNA system.

These requirements would clearly place additional strain on already-stretched resources within Trusts.

c) Metrics

The introduction of a set of metrics which will allow us to monitor progress against the targets has proven particularly challenging. In a cancer system where a patient may be diagnosed at one Trust, but then treated at two or three different Trusts, it is not possible to automatically track Recovery Package activity at an individual patient level – and tracking activity manually for every patient would consume a disproportionate amount of resource.

Therefore, we are currently piloting (at MFT – Wythenshawe) a simplified dataset, which includes a pure count of the number of HNAs performed in-month, against the number of new patients diagnosed. This is similar to the methodology employed by the London Cancer Alliance.

Based on the outcome of this pilot, we will roll this out to all Trusts in May 2018, asking Trusts to provide data for all patients diagnosed from 1st January 2018 to 31st March 2018.

Later in the year we will also perform a detailed audit of the extent of Recovery Package activity in a sample of patients across the region, to give a snapshot of the extent of implementation.

4. Progress to date

In order to achieve the targets, GM Cancer has:

- Ensured that all Trusts and Pathways are fully engaged with this work, with both an executive and a clinical lead named for each Trust (see appendix 2), and by continually briefing and presenting at Pathway Boards, nursing groups/forums, and a range of other local and national educational events.

- Set up a Steering Group to lead the work. This group published the GM-wide standard approach to the Recovery Package in August 2017, and continues to meet monthly to agree the metrics required to monitor progress against the standard.

- Formed an Implementation Group to share learning and support local Trust implementation teams. This has been meeting monthly since June 2017. Representatives from all ten acute Trusts, as well as primary and community care, share progress and concerns. These are fed back to the Steering Group for consideration and action.

- Scoped the current use of Recovery Package elements. (The initial focus was on establishing the current extent of the use of HNA and eHNA across the region. Trusts were asked what percentage of patients had HNAs carried out, and care plans generated, at diagnosis and the end of treatment, from 1st January to 31st March 2017. Whilst there were pockets of good practice across the region, in many localities, and across many pathways, the response was 0%. In others, the relevant data was not being collected, so it wasn't possible to provide a timely response).

- Worked with the IT/informatics lead in the Vanguard team to develop an Information Governance agreement which will allow all Trusts to share their HNA data, and indeed their patients' care plans, across the region. This will also enable us to overcome some of the GM-level data collection challenges which we currently face.

- Worked closely with the GM Cancer User Involvement team to ensure that the Recovery Package is implemented in a way that aligns with the needs and preferences of patients.

- engaged with Macmillan to ensure that all Trusts are provided with the project staff required to deliver the systemic changes necessary to ensure full implementation (pre-2018 Macmillan funding was patchy).

- Sought to access significant funding from the GMHSCP Transformation Fund to support local trusts to implement Recovery Package elements.

- carried out Pathway Mapping events in key pathways (breast, urology, colorectal and gynaecology so far), in order to both understand the challenges faced by staff in implementing the various tools and the range of practices across the region, as well as to gain consensus about the detail of how and where each of the various elements of the Recovery Package could be implemented consistently (IF the necessary resources were provided).

- Learnt lessons from teams both locally and nationally, via formal and informal networks.

5. Next steps

We will continue with close monitoring of the implementation of the recovery package against trajectory as outlined in collaboration with key stakeholders in GM.

We await the announcement of the GMHSCP funding bid in order to accelerate the scale and pace of Recovery Package implementation.

We will review future evaluation from GM Cancer Board as to the long-term financial plan for sustaining this area of work post-2021.

6. Recommendation

The Greater Manchester Cancer Board is asked to:

- Endorse current programmes of work with regards to the implementation and delivery plan for the recovery package in GM, in line with objectives set out in the GM cancer plan.

Appendix 1: Greater Manchester Cancer Recovery Package Steering Group

Chair	Wendy Makin
Deputy Chair	Claire Higham
GM Cancer	Lindsey Wilby and Claire O'Rourke
GM Cancer User	Natasha Smith
GM Commissioning	Coral Higgins
GM Finance	Darren Griffiths
Macmillan Cancer Support	Richard Hunt and Fran Mellor
People Affected by Cancer	Brian Hixson and Sue Taylor
Data and Audit	Joanne Woolley
Primary Care	Dr Mary Ann O'Mara
Palliative Care	Anne-Marie Raftery
Breast Pathway Board	Mohammed Absar (or CNS)
Colorectal Pathway Board	Sajal Rai (or Deborah Hitchen/Jill Taylor)
Prostate Pathway Board	Satish Maddenini (or CNS)
Provider - NW sector	Janet Keegan
Provider - NE sector	Helen Wrench
Provider - Manchester	To be identified
Provider - South & EC	Rachel Noble

Appendix 2: Greater Manchester Cancer Recovery Package Implementation Group and Leadership, by Trust

Trust	**Lead Cancer Nurse/ Macmillan project lead**	**Executive Lead/Clinical Cancer Lead**
Pennine	Alison McCarthy/ Helen Wrench	Nicola Firth/John Calleary
Bolton	Janet Keegan/Astrid Greenbury	Trish Armstrong/Andy Ennis
Wigan	Janet Irvine/Kathryn Place	Ram Sundar/Mary Fleming
East Cheshire	Joanne Humphreys/ Catherine Fensom	John Hunter/ Jalal Kokan
MFT (WW)	Tracy Kelly/Jane Brown/Rachel Noble	Toli Onon/Ian Welch
MFT (MRI)	Pat Jones/Kathryn Chamberlain	Julia Bridgewater/Ajith Siriwardena
Tameside	Carol Diver/Lenny St Jean	Brendan Ryan/Susi Penney
Stockport	Bev Meenan/Recruiting	Pauline Enstone/TBC
Salford	Cath Fitzsimmons/Michael Clinton	Pete Murphy/TBC
Christie	David Wright/Recruiting	Jackie Bird/ Wendy Makin

Other Implementation Group Members:

Chair: Lindsey Wilby

Deputy Chair: Claire O'Rourke

GM Cancer: James Leighton, Michelle Leach, Jane Ashworth, Paula Daley, Steve Smith (PAbC), Dave Kinsey (PAbC), Natasha Smith, James Leighton, Rebecca Price

GM Cancer Vanguard: Liz Islam, Nadeem Ahmed

Primary Care: Liane Harris (Damian Aston represents)

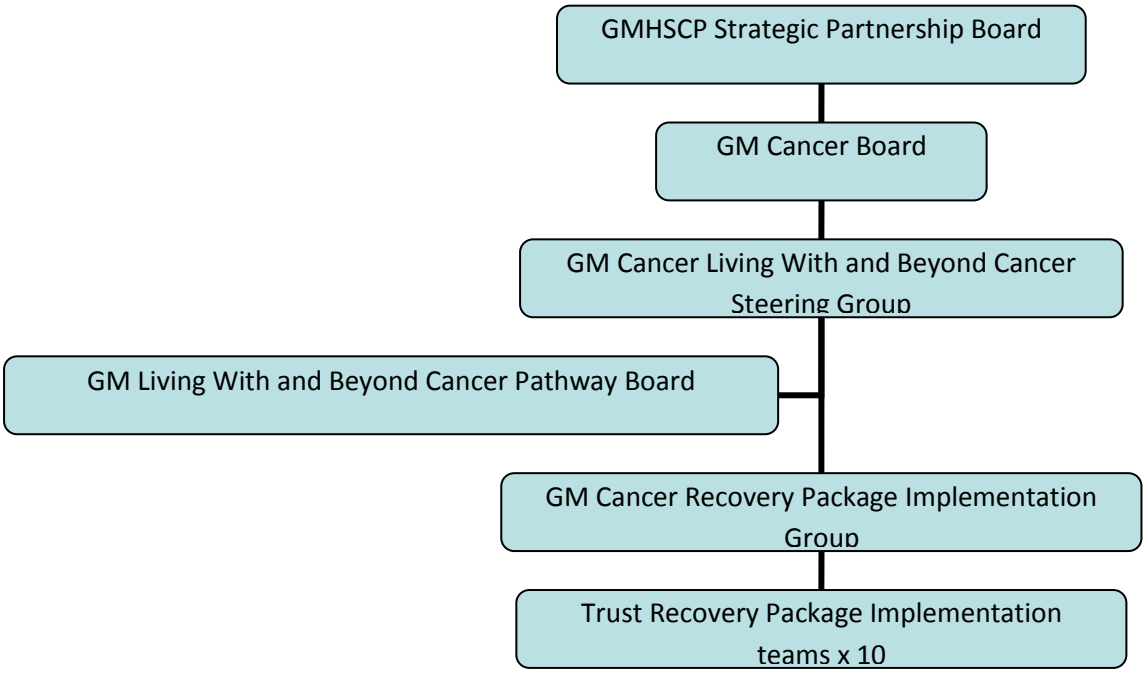
Community: Tracy Acton

AHP: Karen Livingstone, Kathy Pantelides

Psychology: Claire Rehan

Macmillan Cancer Support: Richard Hunt, Fran Mellor, Christine Amica, Caroline Foran

Appendix 3: Greater Manchester Cancer Recovery Package Implementation Governance Hierarchy



Agenda Item No: 9

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	9th March 2018	
Title of paper:	**Process for Cancer Programmes accessing the GM Cancer fund**	
Purpose of the paper:	Provide clarity on process to be adopted	
Reason for Paper: *Please tick appropriate box*	☐	***Decision***
	✓	***Discussion***
	✓	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes	Funding the programmes for cancer are necessary steps in improving outcomes/ experience/ reducing inequality/ minimising variation and driving operational efficiency. Saving 1300 lives and Improving 1 year pooled survival from current 71.5% (2015 data; published 2017) to >75% by 2020/21 & meeting other GM Cancer plan key objectives	
Improved patient experience	As above. See GMC plans objectives in this regard	
Reducing inequality	As above	
Minimising variation	See above	
Operational / financial efficiency	As above	
Author of paper and contact details	Name: Dave Shackley Title: Medical Director GM Cancer Email: david.shackley@srft.nhs.uk Tel: 0161 918 2185	

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Greater Manchester Cancer Board

Paper number 5

Date: 9th March 2018

Title: Process for Cancer Programmes accessing the GM Cancer fund

From: David Shackley

Purpose of paper

To outline the process for individual cancer programmes accessing the funding set aside for cancer within the GM Transformation fund

Background

A preliminary sum of £10 million of transformation funding has been identified from the GM Transformation Fund to facilitate the delivery of the GM Cancer Plan 2017-21 (published Feb 2017: https://gmcancer.org.uk/the-plan/)

The process described is mirrored from other cross cutting GM HSCP programmes and describes the actions necessary in order to secure release of the funding. As with other programmes, this funding will come with material conditions and be subject to ongoing review to ensure delivery and return on investment (clinical and other) remains on track. Additional resources (monetary and other) to fund the programme will also be available from locality, provider, third sector and other sources.

Process

1.0 PID Development

1.1 A detailed PID (project initiation document) will be drawn together for the Programme of Work. This will be led by the designated Project Lead and involve relevant stakeholders in its co-production. A standardised PID template will be provided.

The Case for change should be clearly described along with its alignment to the GM Cancer Plan. The degree of co-production and developmental involvement of core stakeholders especially Users/ People affected by Cancer should be set out clearly.

1.2 The PID must describe the expected improvements/ **impact on patient outcomes**, **patient experience and operational efficiency**. In addition it must clearly set out how the work will **reduce inequality and minimise variation** of cancer care across GM.

1.3 The annualised and total costs of the programme should be described with a detailed breakdown of how all monies will be spent.

1.4 The return on investment should be clearly set out by incorporating the information from 1.2 & 1.3. If necessary a formal cost-benefit analysis should be conducted by GM HSCP's preferred partner, *New Economy*. Challenges in relation to future sustainability should be acknowledged and addressed.

1.5 The Programme Governance should be incorporate into the PID including project reporting and oversight, the risks and any mitigation steps, communication and other programme management and escalation functions.

1.6 A comprehensive process of data collection should form part of the work plan to facilitate ongoing evaluation and allowing tracking against expected objectives especially those described in 1.2, set against any investment.

2.0 Cancer Investment Panel

2.1 A Cancer Investment Panel will be set up and will be a task and finish group representing the Greater Manchester Cancer Board. As it is a sub-group of the Cancer Board, It will be chaired by Richard Preece who will also represent the GM HSCP. It will meet as often as needed.

2.2 The Cancer Investment Panel will represent core stakeholders and the representation will include as a minimum a Person Affected by Cancer/ User, a Senior Clinical Leader, a Senior Commissioner, a Provider Federation Board rep, and a Senior Finance Lead. Due attention should be given to public health issues alongside primary/ community and secondary care. Its first roles will be to decide the timetable for proposed PID's (higher priority programmes will come first) and a schedule for the meetings.

2.3 The Panel members will receive the PID and associated documents 2 weeks before the formal meeting allowing the opportunity for involvement/ discussion with additional sector partners as required.

2.4 The Investment Panel will consider the PID at the formal meeting and decide if the PID can be recommended to the GM Cancer Board and what, if any, material conditions should be applied.

2.5 If a recommendation is proposed, the PID will be presented for endorsement at the next GM Cancer Board

3.0 GM Cancer Board

3.1 Relevant PIDs will be presented within the papers for information section of each Board and sent out to members 7-10 days before each meeting

3.2 The Board will have the opportunity to comment on any recommended PID's. It is not expected that the Board will want to debate in great detail any PID though if necessary this can be facilitated.

3.3 The Board will be asked if it is prepared to endorse the recommendation

3.4 Once endorsed by the Board, as each programme will be below the maximum level set by the GM HSCP of £5 million, the programme can be fully signed off at this stage by the sponsoring GM HSCP executive, in this Case Richard Preece who is the senior responsible officer for the Cancer Programme for GM HSCP.

4.0 Delivery of Programme & Associated Reporting

4.1 The funds will be held via a statutory GM organisation with drawdown dependent on achieving any material conditions.

4.2 Progress reports with an emphasis on impact will be required for review on a regular basis, not less than 2 monthly in the first year, and 4 monthly thereafter if all milestones are being met. On occasion an update to the Cancer Board via a paper/ presentation maybe required.

Recommendations

The Greater Manchester Cancer Board is asked to:

- Consider the process above, suggesting necessary alterations.
- Endorse the process.