# Greater Manchester Cancer Board

## Agenda

**Meeting time and date:** 8.00am-10am Friday 13th July 2018  
**Venue:** Frank Rifkin lecture theatre, Mayo Building, SRFT.  
**Chair:** Richard Preece.

<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>Type</th>
<th>To</th>
<th>Lead</th>
<th>Time</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Welcome and apologies</td>
<td>Verbal</td>
<td>-</td>
<td>Richard Preece</td>
<td>5’</td>
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<tr>
<td>2</td>
<td>Minutes of the last meeting</td>
<td>Paper 1</td>
<td>Approve</td>
<td>Richard Preece</td>
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<tr>
<td>3</td>
<td>Action log and matters arising</td>
<td>Paper 2</td>
<td>Note</td>
<td>Richard Preece</td>
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<td>4</td>
<td>Update from GM Cancer User Involvement Steering Group</td>
<td>paper 3</td>
<td>Note</td>
<td>Sarah Haworth, Nabila Farooq, Ian Clayton</td>
<td>15’</td>
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<td>5</td>
<td>Screening update:</td>
<td>Paper 4</td>
<td>Note</td>
<td>Siobhan Farmer</td>
<td>20’</td>
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<td></td>
<td>▪ Lung Health Check update</td>
<td>presentation</td>
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<td>6</td>
<td>MDT reform in GM</td>
<td>Paper 5</td>
<td>Note</td>
<td>Susi Penney/Dave Shackley</td>
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<td>7</td>
<td>62 day cancer standard:</td>
<td>Presentation</td>
<td>Note</td>
<td>Susi Penney</td>
<td>20’</td>
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<td></td>
<td>▪ GM cancer performance</td>
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<td>8</td>
<td>Macmillan Strategy Update</td>
<td>Presentation</td>
<td>Approve</td>
<td>Fay Scallion</td>
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<td>Paper 6</td>
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<td>9</td>
<td>GM transformation funding update and GM priority 1 plans</td>
<td>Paper 7</td>
<td>Note</td>
<td>Claire O’Rourke</td>
<td>10’</td>
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<td>10</td>
<td>Papers for information:</td>
<td>Verbal</td>
<td>Note</td>
<td>Dave Shackley</td>
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<td></td>
<td>▪ GM cancer conference Update:</td>
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<td></td>
<td>▪ Update Acute oncology Service</td>
<td>Paper 8</td>
<td>Note</td>
<td>Adrian Hackney</td>
<td>5’</td>
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<td>11</td>
<td>Future Meeting Dates:</td>
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<td></td>
<td>▪ 7th September 2018: 8-10am</td>
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<td>▪ 2nd November 2018: 8-10am</td>
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<td>▪ 11th January 2018: 8-10am</td>
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## Minutes of Greater Manchester Cancer Board

**Time & date:** 8.00am-10.00am Friday 5th May 2018  
**Venue:** Humphrey Booth Lecture theatre, Mayo Building, SRFT.  
**Chair:** Dr Richard Preece

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Title/Position</th>
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<tbody>
<tr>
<td>GM Health &amp; Social Care Partnership Team</td>
<td>Richard Preece</td>
<td>Executive Lead for Quality, GMHSC Partnership (Chair)</td>
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<tr>
<td>AGG of CCGs</td>
<td>Rob Bellingham</td>
<td>Director of AGG of CCGs</td>
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<td>Provider Trusts</td>
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<td>Salford</td>
<td>Jack Sharpe</td>
<td>Director of Strategy</td>
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<td>Manchester FT</td>
<td>John Waring</td>
<td>Chief Executive</td>
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<td>The Christie</td>
<td>Roger Spencer</td>
<td>Deputy Medical Director</td>
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<td>Pennine Acute</td>
<td>Roger Prudham</td>
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<tr>
<td>Director of operations group</td>
<td>Fiona Noden</td>
<td>Director of Operations</td>
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<td>MAHSC</td>
<td>Donal O'Donoghue</td>
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<tr>
<td>Patients effected by Cancer</td>
<td>Ian Clayton</td>
<td>User Representative</td>
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<tr>
<td>User Involvement GM Cancer</td>
<td>Sarah Haworth</td>
<td>Macmillan User Involvement Programme Manager</td>
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<tr>
<td>Eastern Cheshire CCG</td>
<td>Mike Clarke</td>
<td>GP</td>
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<tr>
<td>Macmillan Cancer</td>
<td>Tanya Humphreys</td>
<td>Macmillan Services Programme Manager</td>
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<tr>
<td>Medical Director - GM Cancer</td>
<td>David Shackley</td>
<td>Medical Director, Greater Manchester Cancer</td>
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<tr>
<td>Director of Commissioning – GM Cancer</td>
<td>Adrian Hackney</td>
<td>Director of Commissioning – GM Cancer, NHS Trafford CCG</td>
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<tr>
<td>Nursing Leadership</td>
<td>Cheryl Lenney</td>
<td>Director of Nursing, MFT</td>
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<tr>
<td>Christie School on Oncology</td>
<td>Cathy Heaven</td>
<td>Associate Director, Christie SoO</td>
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<tr>
<td>GM Cancer</td>
<td>Claire O’Rourke</td>
<td>Senior pathway manager</td>
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</table>

### In attendance

- OG Pathway presentation: Jonathan Vickers (JV, OG Pathway Director)
- Psychology Pathway presentation: Padraig McDonnell (PD, Psychology Pathway Director)
- 62-day Presentation: Susi Penney (SP, Head and Neck Pathway Director)
- GM Cancer:
  - Rebecca price (RP, GM Cancer)
  - James Leighton (JL, GM Cancer)
  - Michelle Leach (ML, GM Cancer)
  - Ryan Donaghey (RD, Provider Federation Board)
  - Sarah Darley (SD, University of Manchester-RESPECT 21)
1. Welcome and apologies

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

2. Minutes of the last meeting and action log

These were accepted as a true record and there were no subsequent actions.

3. Update from GM Cancer User Involvement Steering Group

IC reported on the recent commissioning meeting held with service users. He confirmed that there was good attendance and all felt that the meeting was a positive one. He went on to say further work and thinking is required to ensure that user involvement is included in the background processes and decision making of commissioning. He therefore requested that, this issue remains open on the Board action plan until this is clarified.

Having attended the recent follow up meeting on 62 days, IC noted the very positive work that has been undertaken across GM, coordinated by GM Cancer Board to make improvements on 62 day performance. This was identified as a key priority by the User Group and they are encouraged to see this work progressing.

He made a plea that whenever GM Cancer originates documents which are templates for board, GM commissioners and/or GM providers, they should in all cases start by quoting the vision of GM Cancer – delivering world class services and outcomes for patients. He emphasised that everyone involved in the system should be aware of and buy into this vision, and that it needs to be the guiding principle to which we all work.

IC also reminded the Board to attach the agreed front page summary to all Board papers so that members can better prepare for the meeting.

SH provided on brief update on the UI Programme progress since the Away Day in February 18. The User group have now drafted aims and objectives for Year 4 of the programme. These were shared with the Board and comments invited before the next Steering Group meeting on Thursday 10th Feb. The UI Programme Annual Report is underway and will be shared with the Board when published.

4. Psychological support for Cancer patients: pathway board update

PD spoke to a presentation on the work of the Psychology Pathway Board. He outlined how patients are supported and their psychological care is delivered. He confirmed that there was variation in the provision of psychological care and a need across GM for training to deliver the required level of support. He advised the Board that a level of investment was now required to minimise the variation and deliver the required service.

CH advised the Board that psychology training was within the Education plan up to level 2 and mentioned the burn out of level 2 staff.

CL asked how staffing could be organised to provide peer support and are the advanced communication skills in GM Cancer at the right level. PD explained that the advanced communication skills were suitable. He went on to say that recruitment was difficult but with the right band and JD right it does remain an attractive option for staff.
JS asked how the GM cancer plan supports the development of psychological services and use of the transformation fund. RPRe advised that PD had articulated the need well but there is more work to be done. He went onto ask why it different for cancer rather than other conditions as many other conditions can similarly cause substantial psychological distress. He said that there was significant investment in mental health from the partnership and he was not sure how we are connecting with that work and tap into all these resources.

RPRe provided a challenge back to the Pathway Board to explore with mental health how this work can connect to prevent fragmentation of services. He then went onto ask that this is brought back to the Cancer Board.

RPRe brought the discussion to a close and thanked PD for his contribution. He invited an update of the psychology proposal to be on the agenda of a future Board meeting.

5. Acute Oncology commissioning specification

RPRe began by saying that he felt that the paper needs to be further developed with a clinical component and input from the pathway board, as he was not sure felt the paper articulated the problem that the specification is trying to solve.

AH responded and spoke to the tabled paper. He advised that the paper built on the national commissioning guidance that was previously circulated. He felt that this was the first step in a process and the next step was to design future model of delivery.

RPRe thanked AH and the group for their work and asked that DS and FN lead and support the design and delivery of the future model of service. He advised that they now need to translate this specification into reality.

RS expressed the view that the service has suffered from not having a single commissioning approach and this has driven the variation. He feels that this has to be resolved and in providing a solution.

TH informed the Board that Macmillan keen to support the development of a future model this year and provide some subsequent funding through 2019 but the case for funding needs to be made in the near future.

6. Oesophago-Gastric (OG) Cancer best practice pathway update

JV presented on the existing OP pathway and the plans to adapt this to meet future demand. He outlined that the service will be changing and that a single service based at SRFT will be commencing in the autumn of 2018.

He began by discussing whether speed in the pathway does improve outcomes for patients or not. He explained that it was difficult to say as not most referrals were not curable and had a lot of locally advanced disease, so much about the pathway redesign was about the patient experience and ensuring that patients are getting the right treatment.

In discussion DoD asked where does shared decision making occur in the pathway and how much choice is there for pts? JV explained that the challenge is in balancing the preferred clinical decision with that of the patient choice or decision.
IC noted how fragmented the pathway was and asked how continuity for the patient is being ensured? JV proposed that this would be better dealt with by the single service being established and standardising the MDT approach to decision making.

CL asked if there is capacity in the system to deliver the pathway. JV replied that reconfiguring the pathway does not change what is happening in the pathway but ensures what does happen is optimally streamlined and efficient. This requires a blended approach with some aspects local, some sector and some a GM approach.

CL followed up by enquiring about the role of the MDT (in general) and how this could be standardised to prevent delays? DS confirmed that the MDT role was to be on the agenda of the next board and a national project is in place to provide better guidance to MDTs.

JS advised that there is a need to be clear on our expectations of the diagnostics within the service.

RPRu asked about recruitment into clinical trials within the single service. JV confirmed that all patients would be going through a single point and then the trials would be delivered within the 3 sectors, probably with a more equitable approach. He felt that the R&D capacity to support this may need optimisation.

RPre brought the discussion to a close and thanked JV for his contribution. He invited an update of the single service is tabled on the agenda of a future Board meeting.

7. GM Cancer Commissioning update

RB spoke to the meeting about commissioning in GM and how this makes links with clinical services. He outlined the commissioning cycle and how this worked in GM. He then went onto outline the commissioning principles especially co-production.

He stressed that he felt it was important that commissioning is integrated with service provision and should not be detached from this, RB then provided an update on the commissioning actions in the cancer plan.

HE confirmed that the establishment of the commissioning hub would ensure better integration of the commissioning plans particularly with localities.

CL thanked RB for his helpful presentation but felt that the Board need these presentations in advance, to allow for better preparation. RP noted this comment and agreed to respond at future meetings. FN thanked RB and agreed with CL.

RS asked that the board should see the commissioning actions within the Cancer plan and how they relate with the current arrangement of commissioning. RPre advised that the next board will provide a paper with that detail.

MC confirmed that Eastern Cheshire recognised the differences in commissioning processes and asked Board to be mindful of these and ensure the routes into care were maintained. RPre confirmed that the Board would work to ensure there was no disruption.

DS advised the Board on the importance of the broader system and in particular GM level cancer commissioning linking up with locality cancer leads (GPs). A recent meeting of the GM locality cancer clinical leads asked for more and clearer guidance on what should be prioritised in cancer.
RB responded by emphasising the need for co-production between the stakeholders and the commissioning hub. He proposed that it was critical that commissioning should be an integrated process that was entwined with all stakeholders. He also noted no GP around the table and RPRe explained that this was being addressed.

8. **62 day cancer standard**
   - New national waiting time guidance update

FN explained how the new standards were implemented and how it was affecting GM. She outlined the actions that Director of Operations group had taken in response to the changes.

She confirmed that there were a number of issues that they were in discussion with NHSE to try and resolve.
   - Cancer leads meeting

SP reported on the second 62-day meeting that was held recently and outlined the actions from this meeting. She also reported on a meeting that was held to support the MDT co-ordinators.

9. **GM Cancer Screening update:** This item was deferred-July 2018.

10. **Cancer intelligence report**

AH outlined how the intelligence service came about and how it might be used in the future.

CoH spoke about the tabled paper. She explained that the CI team had 3 objectives and had now met two of them. She confirmed that the data reports are available and advised that if members had not received an invite they should email CoH or the cancer intelligence team at the Christie, for a login. She then went onto to describe and demonstrated the report portal.

SP asked how data is provided from Trusts to support this work and how this might contribute to the work of GM Cancer. RP suggested that next time she come to meeting to show how data has supported change.

SP suggested that the portal could house the proposed GM provider cancer diagnostic information, and enable sharing of Cancer waiting time data more effectively between providers, the partnership and commissioners.

IC regretted that patients and Macmillan are not allowed to see the data and felt that this weakened their position as Board members. CoR explained that this was related to information governance. RPRe felt that this needs to be addressed and asked that all members of the Board have access to the database.

11. **Cancer Workforce strategy: - Health Education England update**

CoR spoke about the tabled paper and outlined the programme of work and went onto outline the outputs from this report. She confirmed there were a number of meetings set up to review and plan the response from this report.

RP asked for further reports and updates on this work. CH advised that this work was more about having the right skills in the workforce rather than just the numbers.

12. **Breast screening**

DS informed the Board that following the recent reports on missed Breast screening appointments (a national issue) a GM response was in place and is being led by the Public Health team at the Partnership.

13. **Date of next meeting : 13th July 2018**
**Greater Manchester Cancer**

**Action log**  
Prepared for the 13th Jul7 2018 meeting of the board

<table>
<thead>
<tr>
<th>ACTION</th>
<th>AGREED ON</th>
<th>STATUS</th>
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</table>
| 1      | Acute oncology: commissioning service specification to be completed | 3rd November 2017  
Update for Acute oncology and Paper for GM cancer board 13th July 2018 |
| 2      | MDT reform: DS to report back to GM cancer board in July on progress on pilots | 3rd November 2017  
Paper for GM cancer board 13th July 2018 |
| 3      | JP to provide an action plan and update on the screening to the GM Cancer board in July 2018. | 12th January 2018  
Paper GM board 13th July 2018 |
| 4      | Progress report on Genomics Board to report back to the GM cancer board in September 2018. | 12th January 2018  
Paper GM board 7th September 2018 |
<table>
<thead>
<tr>
<th>Name of Meeting:</th>
<th>Greater Manchester Cancer Board</th>
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<tbody>
<tr>
<td>Date of Meeting:</td>
<td>Friday 13th July</td>
</tr>
<tr>
<td>Title of paper:</td>
<td>Macmillan User Involvement Programme, Aims and Objectives Year 4</td>
</tr>
<tr>
<td>Purpose of the paper:</td>
<td>To inform Cancer Board of the UI Programme’s 2018/19 aims and objectives, and revised reporting structure.</td>
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<tr>
<td>Reason for Paper:</td>
<td>For information</td>
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<tr>
<td>Impact</td>
<td>Please state how the paper impacts on:</td>
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<tr>
<td>Improved patient outcomes</td>
<td>The UI Programmes aims to have service user representation on all GMC Pathway Boards and key projects ensuring a user perspective in all aspects of service development to improve services.</td>
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<tr>
<td>Improved patient experience</td>
<td>User Representatives are ‘experts by experience’, by bringing their own experience and knowledge of services to combine with professionals and work together in partnership we aim to improve services for other service users in the future.</td>
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<td>Reducing inequality</td>
<td>The UI programme connects with service users and user groups from across GM to gather feedback and views which are then represented in the Pathway Boards and workstreams.</td>
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<td>Minimising variation</td>
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<td>Operational / financial efficiency</td>
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| Author of paper and contact details | Name: Sarah Haworth  
Title: Macmillan User Involvement Programme Manager  
Email: sarah.haworth1@nhs.net  
Tel: 07500 981513 |
1 Introduction

The Macmillan User Involvement (UI) Programme is now entering its fourth year; this paper sets out the programme’s aims, objectives and key deliverables for 2018/19 which have been co-produced with over 40 people affected by cancer. Alongside this the UI Programme has reviewed its governance structure to align with Cancer Board, the reporting structure is outlined in this document.

2 Background

The UI programme has developed a robust and meaningful approach to user involvement and works with over 100 people affected by cancer from across Greater Manchester and East Cheshire. The programme supports the work of Greater Manchester Cancer in its vision to deliver world class cancer services. The programme uses a co-production model, bringing service users and professionals to work together as equal partners to improve cancer care and services. The programme ensures meaningful involvement of service users at a system level through the Pathway Board infrastructure and in GM transformation projects. It also has a key role in developing awareness and building experience of effective user involvement and co-production across the system.

In February 2018, the UI Programme held a development day with 35 people affected by cancer to review progress to date and consider the future direction of the programme. During the session, service users considered some key areas of the GM Cancer Plan to agree what they felt were priorities from a user perspective and therefore areas which the UI Programme should focus on this year. These three areas were early intervention and prevention, best timed pathways and waiting times, and psychological support for people affected by cancer. These priorities will be reinforced by the UI Programme’s User Representatives during their work within GM Cancer.

The following vision, aims and objectives were co-produced with people affected by cancer who have been involved in the work of Greater Manchester Cancer over the past year. These were shared in draft at the GM Cancer Board in May, they have since been further developed by the UI Steering Group into a full work plan with deliverables and timelines.
User Involvement Programme Vision, aims and Objectives

Our Vision

People affected by cancer and healthcare professionals are equal partners in the co-design, monitoring and improvement of cancer services, supporting Greater Manchester Cancer to deliver world class cancer outcomes.

Programme Aims

- To support delivery of Greater Manchester’s vision to achieve world-class cancer outcomes by aligning user involvement opportunities with the Greater Manchester Cancer Plan.
- To embed meaningful user involvement within Greater Manchester Cancer ensuring people affected by cancer are an integral part of developing, monitoring and improving cancer services at all levels.
- To promote diversity within user involvement, ensuring Greater Manchester Cancer is inclusive, listening and influenced by the diverse experiences of people affected by cancer from across the conurbation.
- To develop a shared understanding of user involvement in Greater Manchester and East Cheshire where co-production and working in partnership as equals with healthcare professionals is the norm.
### 3.3 Programme Objectives, Deliverables and Timelines

<table>
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<tr>
<th>No</th>
<th>Objectives</th>
<th>Deliverables</th>
<th>Timelines</th>
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<tbody>
<tr>
<td>1</td>
<td>Ensure robust service user representation across all the GMC Pathway Boards and other key on-going programmes of work linked to the Cancer Plan within GMC</td>
<td>Two Service User Representatives on every Pathway Board</td>
<td>Continual process monitored quarterly</td>
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<td>Appropriate number of Service User Representatives (SUR) on key projects/programmes of work</td>
<td>Continual process monitored quarterly</td>
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<td>Develop a rolling recruitment and succession plan for Pathway/Project/Cancer Boards</td>
<td>August 18</td>
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<td>Co-produce quarterly reporting format for UI Steering Group (UISG) to monitor progress of representation</td>
<td>August 18</td>
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<td>2</td>
<td>Ensure service user involvement is sustainable across all the GMC Pathway Boards and other key on-going programmes of work linked to the Cancer Plan within GMC</td>
<td>Recruit at least one Health Care Professional (HCP) from each Pathway Board who will be the named ‘mentor’ for SURs</td>
<td>To be achieved for all boards by March 19</td>
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<td>Create a network for the HCP ‘mentors’ to offer support and leadership from MUIT</td>
<td>December 18</td>
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<td>3</td>
<td>To ensure effective and efficient use of resources to support key areas of work where user involvement can have most impact</td>
<td>Co-produce a report which contains each Pathway Boards key priority areas for user involvement which will be monitored by UISG</td>
<td>October 18</td>
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<td>Co-produce a quarterly service user involvement activity report to capture work completed in Pathway Boards</td>
<td>October 18</td>
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<td>Ensure priorities identified by Service Users on UI Programme development day are integral to the work of the Pathway Boards and SUR’s are involved in development and monitoring of these</td>
<td>Identify clear plan with each Pathway Board Director how these areas of work are being addressed by the Board</td>
<td>October 18</td>
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<td>No</td>
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<td>5</td>
<td>Ensure the UI Programme service users are reflective of diversity of the GM and East Cheshire population</td>
<td>Co-produce a bi-monthly reporting format for UISG to monitor the membership of the UI programme</td>
<td>August 18</td>
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<td>Create targeted recruitment plan to address gaps and recruit or engage with under-represented groups</td>
<td>September 18</td>
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<td>Provide evidence of steps taken to improve representation within the UI Programme</td>
<td>Continual process monitored quarterly</td>
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<td>6</td>
<td>Ensure there is an appropriate structure to enable Service Users on Pathway Boards to be representative of the wider voice of people affected by cancer</td>
<td>Review current ‘small community’ structures and effectiveness</td>
<td>September 18</td>
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<td>Agree an action plan with timescales to develop ‘network/small community’ for each Pathway Board</td>
<td>October 18</td>
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<td>7</td>
<td>Develop a shared understanding with Healthcare Professionals on Pathway Boards (HCPs) of meaningful user involvement and co-production in cancer services</td>
<td>Co-produce user involvement awareness sessions for HCPs</td>
<td>November 19</td>
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<td>Run a minimum of 3 sessions and monitor uptake by HCP</td>
<td>March 19</td>
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<td>Co-produce and deliver User Involvement presentation at every Pathway Board</td>
<td>December 18</td>
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<td>Undertake a baseline audit of HCP knowledge and understanding of user involvement</td>
<td>September 18</td>
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<td>8</td>
<td>Promote and share learning from the GM User Involvement Programme across</td>
<td>Create Best Practice Toolkit</td>
<td>November 18</td>
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<td></td>
<td>Greater Manchester and East Cheshire Conduct benchmarking exercise with other areas outside GM and East Cheshire</td>
<td>February 19</td>
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<td>Develop a UI GM Communication and Engagement Strategy</td>
<td>September 18</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Support personal and professional development of Service User Representatives within the Programme Develop training package for SURs</td>
<td>January 19</td>
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<td></td>
<td>Create ‘Buddy’ system within the Programme</td>
<td>March 19</td>
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<td></td>
<td>Hold 3 Networking/Peer to Peer events each year for Service User Representatives to share experience and best practice with each other and HCPs</td>
<td>March 19</td>
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</table>

### 4 User Involvement Programme Reporting Structure

Alongside the work to review the programme aims and objectives, the UI Steering Group have also reviewed the Programmes reporting structure which consists of the UI Steering Group and the UI Programme Board. The role, function and membership of each group has been considered and revised to in line with the evolution of the UI Programme and the changes in Greater Manchester Cancer.

#### 4.1 Role of the UI Steering Group

Membership of the Steering Group is made up of 15 people affected by cancer and members of the MUIT. The Steering Group lead the development and co-production of the UI Programme annual objectives and work plan. It is responsible for monitoring progress of the work plan on a monthly basis and provides guidance and recommendations to support effective delivery of the objectives. The UI Steering Group act as a communication hub and receive progress reports/recommendations from Pathway Board Representatives and working groups. Through the work they do and having an overview of involvement across the pathways, they also highlight any areas of concern, such as gaps in service, poor patient experience or lack of user involvement in service developments. The Steering group report progress of the work plan to the UI Programme Board on a quarterly basis.

#### 4.2 Role of the UI Programme Board

Membership of the Programme Board is made up of Service User Representatives from the Cancer Board and Steering Group, Macmillan and Greater Manchester Cancer Core Team. The Board is responsible for overseeing at a strategic level the Macmillan User Involvement Programme at
Greater Manchester Cancer. It provides assurance of a comprehensive approach to involving people affected by cancer and ensures the UI Programme is aligned with strategic objectives of Greater Manchester Cancer and Macmillan Cancer Support. The Programme Board will receive progress reports and any recommendations from the UI Steering Group. Service User Representatives on Cancer Board will provide an update to Cancer Board on progress of the UI work plan on a bi-annual basis and will raise any significant concerns/risks by exception.
Name of Meeting: Greater Manchester Cancer Board

Date of Meeting: Friday 13th July 2018

Title of paper: Greater Manchester Lung Health Check Prototype

Purpose of the paper: This paper aims to update the board on the work around developing a Lung Health Check programme for Greater Manchester (GM). This paper introduces the potential prototype for the early identification of lung cancer in order to start the process of gathering the views and involvement of the wider system in GM.

Reason for Paper: Please tick appropriate box

- Decision
- Discussion
- For information

Impact Please state how the paper impacts on:

Improved patient outcomes
- Lung cancer is the single biggest cause of premature mortality in GM. One way to improve outcomes for lung cancer is to ensure that those with lung cancer are identified earlier at a more treatable stage of disease.
- In the Macmillan Cancer Improvement Partnership (MCIP) City of Manchester Pilot, 3% of the 1,384 people scanned had lung cancer. Of these, 80% were in early stage and 65% had surgical resection.
- Adopting a GM wide lung health check programme could ensure that more people in GM with lung cancer are identified earlier and may therefore have a longer life expectancy.

Improved patient experience

Reducing inequality
- Traditionally people from more deprived backgrounds and areas have been less likely to take up the offer of screening. In the City of Manchester Pilot, 75% of attendees were from the most deprived quintile. This shows that the lung health check programme has the potential to be acceptable and accessible to people from more deprived areas.

Minimising variation
- Currently lung health checks are not available across the borough of GM. The pilot provided checks for 14 GP practices across Manchester, and an extension of the Pilot will provide
further checks for the residents of North Manchester.
- Currently, therefore, there is a variation across GM where residents of one borough have access to the programme, but others do not.
- Developing a GM wide programme would ensure that this was available to the eligible population across the city region and aim to improve outcomes across the conurbation.

### Operational / financial efficiency

| Author of paper and contact details | Siobhan Farmer, Healthcare Public Health Consultant & Screening and Immunisation Lead  
Greater Manchester Health & Social Care Partnership  
siobhan.farmer@nhs.net Mobile: 07702 411229 |
Purpose of paper

This paper updates the board on the work of the Greater Manchester Health and Social Care Partnership (GMHSCP) to develop a targeted lung health check programme across Greater Manchester. This paper introduces the potential prototype for the early identification of lung cancer in order to start the process of gathering the views and involvement of the wider Greater Manchester system.

Recommendations

The Greater Manchester Cancer Board is asked to:

1. Consider the suggested prototype for lung health checks, building from the Macmillan Cancer Improvement Partnership (MCIP) City of Manchester Pilot to a rolling Greater Manchester-wide approach.
2. Endorse the introduction of this prototype to the wider Greater Manchester system in order to explore the feasibility of a Greater Manchester-wide lung health check programme.

Contact

Rebecca Fletcher, Registrar in Public Health, PHE
Rebecca.fletcher@phe.gov.uk Tel: 0161 234 9630

Rachel Allen, Population Health Project Manager, Greater Manchester Health & Social Care Partnership
rachel.allen12@nhs.net Tel: 07976 661555
Greater Manchester Lung Health Check Programme Update
July 2018

We are aiming to identify lung cancer earlier and to increase the survival rates for people with lung cancer in Greater Manchester.

As part of this work we have been developing a way to carry out lung health checks on people who are at high risk of developing lung cancer in Greater Manchester. This has been developed using the best available research and evidence currently around.

This work is part of the Greater Manchester Population Health priority to prevent and detect cancer earlier. The prototype has been developed by the GMHSCP in collaboration with members of the MCIP City of Manchester Pilot team, clinicians, commissioners including specialised commissioning, public health consultant expertise, primary care colleagues, the Greater Manchester tobacco control programme and finance colleagues.

Key benefits to the people of Greater Manchester

- People would get quick access to lung health tests in mobile units in their community i.e. car parks, community centres.
- More people could have their lung cancer identified earlier therefore less preventable deaths.
- Lung health scanners also detect other conditions such as Chronic Obstructive Pulmonary Disease (COPD).

What is the current position in Greater Manchester?

Lung cancer remains the biggest cause of premature death in Greater Manchester and 80-90% of lung cancers are caused by smoking. Although survival rates for lung cancer are improving, there is still a long way to go. We want to identify those people who have lung cancer earlier in their disease, when it is more susceptible to treatment. This could lead to an increase in the numbers of people surviving with lung cancer across Greater Manchester.

In 2016, a pilot was conducted through MCIP and the three Clinical Commissioning Groups in Manchester involving 14 GP practices. This pilot tested a lung health check programme offering people aged 55-74 at high risk of lung disease the opportunity to attend a lung health check. If this found their risk of developing lung cancer was high, they were offered an immediate low dose CT scan that same day. This service was provided in the community in mobile units.
2,541 people attended their lung health check and of these, 1,384 had a scan following the risk assessment. Of those that were screened, 3% had lung cancer. Vitally, of these, 80% were in early stage and 65% had surgical resection (Crosbie et al, 2018).

Following these results, we established a Steering Group and a Task and Finish Group in 2017 to assess the evidence, and develop a model for lung health checks in Greater Manchester. These groups have now appraised the evidence, and worked with the professionals involved in the pilot to develop a prototype for a programme that can be used across the whole of Greater Manchester.

**Patient Involvement**

We have two patient representatives who sit on the Greater Manchester Lung Health Check Steering Group. Their input has been invaluable in developing the prototype. We will now take the plans to patient groups to help ensure they are right for the people of Greater Manchester.

**What is known about lung health checks?**

Lung Cancer Screening with low dose CT scans is available in some countries, in particular the USA and Canada. In the UK, the National Screening Committee (NSC) is the body that advises the government on screening programmes. Current national screening programmes include bowel, breast and cervical cancer. At this time, the NSC does not recommend lung cancer screening. They are waiting for more evidence before deciding whether to progress further work on a national programme. Despite the UK NSC position, NHS England announced that they are planning on expanding lung cancer testing for high risk individuals, specifically referencing the success of the City of Manchester Pilot (Wise, 2017). In addition, other areas are also looking to take forward programmes aimed at early diagnosis of lung cancer.

A Greater Manchester lung health check programme would therefore not be an official national screening programme, as national screening programmes are approved by the NSC. Instead, it would be a health check programme aimed at providing high risk individuals with access to health information, and CT scans. It is based on the same principles of screening though: people who appear healthy in a higher risk population will be invited to undergo a test to identify those at even higher risk of disease. **The aim is to detect signs to indicate that lung cancer may develop, or has developed, in people who otherwise feel entirely well.**

**Challenges**

There have been a number of international trials of CT scan screening for lung cancer. The largest was an American study, the National Lung Screening Trial (NLST). In the UK, many experts consider that the evidence is not strong enough in terms of the population benefit, impact on mortality, and cost-effectiveness. The cost of providing CT scans for a large number of people could instead be used on interventions with higher levels of evidence such as smoking cessation provision.

There are a number of challenges to population testing in order to diagnose lung cancers
earlier. It is important to remember that testing a seemingly healthy population can cause harm as well as benefit. For example, potential harms include diagnosing people with cancer who do not have the disease (false positives). Information from trials suggests that there can be a large number of false positives from low dose CT scans. False positives cause harm through anxiety, and having treatment that was not needed (Parvulescu et al, 2015).

Some cancers will be found that would not have otherwise required treatment because these include some slow developing cancers, and cancers in people who die from non-related conditions. International evidence suggests that this could apply to up to 18% of lung cancers found via this form of testing (Patz et al, 2014).

There are no live large scale randomised trials currently being undertaken on CT scan lung cancer screening. It appears to be unlikely that the trials that are waiting to be published will provide a large amount of new evidence to inform future screening plans. These trials used a variety of models, including inviting different groups to be screened and using different risk thresholds.

What are the plans?

Following the development of the prototype for a Greater Manchester lung health check programme, we now will talk to colleagues and partners across greater Manchester about the plans.

The diagram below shows the whole proposed process for lung health checks. Key features include:

- A risk assessment carried out in the check that will determine who requires a scan.
- A risk stratified model where most people will have a 2 year follow up but those at higher risk will have follow up scans more quickly.
- The prototype also includes explicit inclusion of smoking cessation and is designed to be a rolling programme where individuals identified as being eligible for a scan will be followed up for 6 years.

### Lung Health Check Prototype: Patient Journey

**Invitation:**
- All 55-74 year olds are sent a letter explaining the lung health check programme and asking them if they are eligible.
- Those that consider themselves to be eligible and wish to take up the lung health check then call a central phone number to book an appointment.

**Health Check:**
- The lung health check will be carried out in a mobile unit based in community setting
- The check involves a discussion with a trained nurse, a risk assessment, and, if a smoker, a smoking cessation “brief intervention”, and an opt-out referral to a smoking cessation service.
- Those whose risk is calculated to be less than 3% are then given information about symptoms and then leave. At this point they have completed their lung health check.
- Those whose risk is calculated to be 3% or more are then invited to a scan straight away within the same mobile unit.

**Referral:**
- Those with positive scans (scans indicating probable lung cancer) will then be referred into secondary care.
- GPs will be informed of other findings including other respiratory conditions

**Follow up scan interval:**
- The results of the scan are then used to stratify the follow up for high-risk participants.
  - 2 year interval – those with clear/low risk scans
  - 12 month follow up scan – those with medium / small nodules/risk
  - 3 month follow up scan – those with higher risk/nodules

**Number of rounds**
- Each participant who is risk assessed and then receives a scan will then have scans a minimum of every 2 years for 6 years. They won’t have another full lung health check but will instead just go straight to the scan in the follow up years. According to the existing evidence, the risk assessment is accurate for 6 years and so for this length follow up, they do not require another full lung health check.

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**Cost Benefit Analysis**

A Cost Benefit Analysis (CBA) process has been undertaken by the Greater Manchester Combined Authority (GMCA) Research Team, using the HM Treasury-approved New Economy CBA model. Our work to date has been informed by data from the 2016 MCIP City of Manchester Pilot, modelled estimates of the number of current/ever smokers in Greater Manchester through Public Health England (PHE), and cost data.

This analysis suggests that over 6 years, this programme might help identify up to 8,000 patients with lung cancer. Of these people, we think that up to 5,500 could have surgery that may help to prolong their life.
Our analysis suggested an average cost of about £6m a year, based on a total of £47m over the 8 years of the programme (a staggered rollout across Greater Manchester of a 6 year programme). This figure is the first iteration of potential costs, and further discussions will be required with providers, and local commissioners regarding the impact on the wider health system, and potential benefits and harms to people who choose to have a check.

Our calculations use a number of assumptions based on emerging evidence from the Pilot but there are a number of areas where no evidence exists, and therefore the figures should be interpreted with caution. There are likely to be additional benefits to the population and within the health system due to the impact of smoking cessation and greater awareness of lung cancer symptoms. In addition to finding signs of possible lung cancers, the lung health check and scan may also find evidence of other conditions. These would contribute to the overall effectiveness of the programme. Most lung cancer screening programmes do not systematically provide evidence against these findings. The Greater Manchester lung health check model would include ensuring the appropriate information on these other conditions is available to patients, who will be referred to the appropriate health care professional for support.

**Outcome:** We are introducing this potential model for the early identification of lung cancer to seek the views and involvement of the wider system in Greater Manchester. This is an opportunity to widen the discussion with a broad range of partners.

**Further information**
http://www.cancerresearchuk.org/about-cancer/lung-cancer
https://legacyscreening.phe.org.uk/lungcancer

**Contact details**
Report of Dr Richard Preece, Executive Lead for Quality of the Greater Manchester Health and Social Care Partnership, Chair of Greater Manchester Lung Health Check Steering Board and Greater Manchester Cancer Board.

**References**
**Name of Meeting:** Greater Manchester Cancer Board  
**Date of Meeting:** 13\textsuperscript{th} July 2018  
**Title of paper:** MDT Reform  
**Purpose of the paper:** To update the Board on the national and local context and proposed next steps for MDT reform across GM Cancer

**Reason for Paper:**  

| Decision | Discussion | For information |

**Impact**  

| Improved patient outcomes | Refined MDT’s will enhance reliability of care, will facilitate deeper more in depth conversations of complex patients and will be in line with national thinking and strategy. Clear pathways will result in more reliable research/trial discussions and minimise unwarranted variation in treatment options |
| Improved patient experience | As above. Primarily standardised care and a quicker time to MDT decision should result from this work |
| Reducing inequality | As above |
| Minimising variation | As above |
| Operational / financial efficiency | As above. More flexible use of clinical staff |

**Author of paper and contact details**  
Dave Shackley, Susi Penney, Neil Bayman  
David.shackley@srt.nhs.uk
MDT Reform in Greater Manchester Cancer: July 2018

Authors: Dave Shackley, Susi Penney & Neil Bayman

1. Background:

Multi-disciplinary team meetings (MDT) are central to the management of patients with cancer. They were introduced over 20 years ago to reduce variation in decision-making and access to best care for patients with cancer and their carers. However, there is growing evidence that MDTs have not been working as effectively as they could. Against this background, Greater Manchester Cancer, our integrated cancer system in Greater Manchester (GM), were set the task of reviewing MDT effectiveness. The aim was to determine how a variety of MDTs currently work and make recommendations to improve MDT working and effectiveness in GM to improve patient care and outcomes.

The MDT serves to allow multiple professional opinions and a consensus to form on individual patient’s best treatment options, to standardise care, facilitate team working, including supportive and palliative care and encourage research, data collection and improve training. There is resounding support for all clinical staff to the prime importance of the MDT process in delivering excellent patient care. However, over a number of years, MDTs have come under increasing pressure due to:

- Significant increases in caseload
- A change in case-mix including patients with greater comorbidities as a result of an ageing population and increasing number of complex treatment options.
- This increase in numbers/ complexity of cases to be discussed has not been matched by any increase in time set aside for the MDT.
- Some MDT meetings are sometimes poorly attended by individuals, others by speciality expertise, and there are issues relating to consistent, reliable information technology, data collection and infrastructure such as videoconferencing.
• The necessary information regarding the patient and their tumour is not always available to the MDT resulting in a delay and repeated listing for discussion, and the potential for poor decision-making.

• MDT meetings require adequate preparation, effective chairing with engagement and proactive involvement of MDT members to ensure proper discussion of the case and the ability of the chair to encapsulate the discussion into a clear outcome. There is evidence that there is a wide variation in MDT leadership such that this is not always achieved.

• It is difficult for specialists to fully focus on every case with very long MDT’s, which can run into many hours in some cases.

All these pressures could potentially lead to delayed or suboptimal decision-making about treatment.

2. Rationale for MDT reform in GM

Two recent important reports have recommended changes in MDT working in the UK, which has informed this review of MDTs in GM. Amongst other recommendations, the report of the Independent Cancer Taskforce has recommended that NHS England should encourage providers to streamline MDT processes such that specialist time is focused on complex cancer cases with other patients being discussed more briefly. Speciality representation should be mandatory rather than the 66% individual attendance previously mandated.

The recently published report from Cancer Research UK has also made a strong recommendation to identify pathways for protocolised treatment for the straightforward cases, leaving more time for discussion of complex cases. The report also recommended the development of proforma templates to ensure that all the necessary information about the patient, the performance status and the comorbidity is included in the referral. Evidence from both reports has suggested:

• Cost of MDTs is rising at annualised rate of >20% (pro-rata estimation GM would be just under £9 million per year with typical cost of each MDT discussion being £100)

• Meetings can last up to 5 hours with mean length of patient discussion being 3.2 minutes

• Average number of attendees was 14 but mean number of people contributing to each discussion was 3; In >75% MDT discussions there was no verbal contribution from nurses

• 74% MDT members agree that some patients can be reviewed outside the full MDT process

• 80% MDT attendees support move from requiring a >66% individual attendance to focus more on speciality cover
• 7% discussions had decisions deferred because of missing core members or missing diagnostic tests

• 81% of MDT members felt that using a proforma would be beneficial in terms of meeting efficiency

• Only a minority of MDT discussions mentioned research at all (CRUK study of consecutive discussions observed= 8/624).

3. Proposed Changes

As a result of the 2 reports described above, NHSE are currently considering a series of recommendations for MDT’s across England with this report and related alliance guidance expected late 2018. This work is being led by Chris Harrison (National Clinical Director for Cancer) and Martin Gore (Ex Medical Director of the Royal Marsden). Appendix 1 sets out a recent presentation by Martin Gore in summer 2018 highlighting the current view.

Notwithstanding this, GM does not necessarily need to await the national report as the direction is clear and it is widely anticipated that the following issues need careful local consideration:

- spending more time discussing patients with complex clinical issues - stratify patients
- speciality cover rather than individual attendance
- Sectorisation of MDTs (as demonstrated in lung)
- Diagnosis tests must be complete before MDT
- standardised minimum dataset available for each patient
- learn from significant events based on decisions making processes
- The frequency of MDT’s balancing the need for timely discussions and the limits of staff time and workforce

In addition, the recently published NHSE National Accelerated Cancer Pathways work (https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/) uses day 21 of the pathway as the latest time for the MDT to give sufficient time to speak and meet the patient by day 28 (and therefore meet the Faster diagnosis standard). This means that a time optimised, streamlined approach is required as part of any MDT reform
Summary of key steps:

- **Spending more time discussing complex patients, and less on ‘routine’ cases** – this requires some form of triage/mini-MDT process with simpler cases being treated according to locally agreed protocols but where data entry and other key steps still take place. An audit/governance process would need to be described to assure patients, clinicians and the ‘system’ that a refined MDT process is being appropriately and reliably delivered.

- Seems to be a consensus that speciality cover rather than individual attendance is mandated at the main MDT meeting and this should be identified as the key metric. This also allows clinicians who attend the current MDT’s to be part of a rota of different clinical steps in the new process and not all have to attend a single MDT meeting each week. Team working and cross cover are vital.

- A degree of sectorisation, or in cases of rarer tumours, GM-wide MDT’s need to be considered to ensure all meetings are quorate with speciality expertise and cross cover. Clear communication and reliable videoconferencing facilities are critical.

- **MDT’s by day 21 means that a streamlined reliable system be in place to ensure all appropriate tests are in place before discussion. More use of pathway navigators seems sensible with pre-agreed pathways which do not require doctor approval to move onto next step (unless exceptions)**

- Creating a system so that a standardised minimum dataset is available for each patient, (eg ensuring details on performance status, HNA, patient preference and other key information is available during the discussion), and that there is effective recording of Stage/ Grade and MDT outcomes – this will likely be tumour site specific. We also need to capture data in line with national audits where applicable.

- Ensuring MDT’s can review and learn from recent significant events based on their decisions making processes. This is especially the case where patients come to harm after treatment based on an MDT decision.

- **The frequency of MDT’s balancing the need for timely discussions and the limits of staff time and workforce needs to be considered for each pathway.**

It is anticipated that clinical involvement that currently sits entirely within an MDT, will be distributed into a broader MDT process (involving triage, 'mini MDT', information input, refinement of protocols, audit/oversight and significant events review). Clinicians may need to rotate through these different roles.
4. **GM Cancer proposed actions**

- Detailed mapping and visits to all speciality MDT’s across GM to assess degree of sectorisation required to optimise MDT attendance and explore feasibility and attitudes towards MDT reform. It is anticipated that certain sub-specialities may have credible reasons to maintain the current system. Interim report Nov 2018

- Work with all pathways to explore ways of formalising team discussion of significant events following MDT decisions. Plan in place by Nov 2018

- Work with 2 specialities to create local protocols to pilot prospective pathways. January 2019. Work with NHSE’s national MDT reform team to ensure GM learns from other ideas and case studies/ pilots. To visit centres of excellence where MDT reform as ‘prospective pathways’ has been successfully trialled

- Set up a GM-wide MDT workshop to get broader system engagement and build momentum Feb/ March 2019

5. **Recommendations for the Board:**

The board is requested to approve the proposed steps
Appendix 1

Multidisciplinary Team Meetings improvement: redesign for the NHS

UK Radiological Congress and Radiation and Oncology Congress
Liverpool, July 2018

Marlin Gore
Royal Marsden Hospital
Institute of Cancer Research
London

Multidisciplinary Team Meetings

Transforming Multidisciplinary Team Meetings (MDTMs)

Variation in cancer outcomes
MDTMs as a problem
Outcomes and MDTMs
MDTMs in the new world
Variation:

**Global cancer survival, 2000-14 (CONCORD-3)**
Analysis of individual records: 37,513,925 pts / 18 cancers / 75 countries
Age-standardised 5-year net survival breast cancer

**Eurocare-5, 2015**
5-year survival all cancers for the period 2000-2007

<table>
<thead>
<tr>
<th>Country</th>
<th>5-year survival</th>
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<tbody>
<tr>
<td>Denmark</td>
<td>66%</td>
</tr>
<tr>
<td>England</td>
<td>68%</td>
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<tr>
<td>Spain</td>
<td>67%</td>
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<tr>
<td>Ireland</td>
<td>67%</td>
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<td>The Netherlands</td>
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<td>Italy</td>
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<td>Norway</td>
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<td>Germany</td>
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<td>Ireland</td>
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<td>Sweden</td>
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**Deaths from common cancers by geography (England)**
Diagnosis 2008-2010, follow up 2015

<table>
<thead>
<tr>
<th>Cancer</th>
<th>5-year survival across England SIs</th>
<th>5-year survival across London</th>
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<tbody>
<tr>
<td>Colorectal</td>
<td>53.6 - 68.5%</td>
<td>53.6 - 68.0%</td>
</tr>
<tr>
<td>Breast</td>
<td>78.7 - 85.8%</td>
<td>78.7 - 82.5%</td>
</tr>
<tr>
<td>Lung</td>
<td>7.2 - 21.7%</td>
<td>11.6 - 31.7%</td>
</tr>
<tr>
<td>Prostate</td>
<td>70.6 - 90.2%</td>
<td>85.5 - 87.8%</td>
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**2-year cancer-specific mortality following major resection for colorectal cancer**

**MDTs as problem**

**Meeting Patients’ Needs:**
Improving the effectiveness of multidisciplinary team meetings
Duration of discussions about individual patients

**Multidisciplinary Team Meetings**
Royal Marsden data

- All MDTMs in June 2010 (rectal, head and necks, breast)
- 551 new patients, 52 MDTMs, 14 tumour sites
- 56% discussed at 1 MDTM
- 42% discussed 2x2 at tumour site-specific MDTM

Subsequent study:
61 patients documented plan by the consultant (2/9) before MDTM (10)

88% concordance, consultant plan and MDTM consensus
12% non-concordance, consultant plan and MDTM consensus
5% major alterations to the consultant plan
2% minor alterations to the consultant plan
**MDTs and outcomes**

Impact of multidisciplinary team: a systematic review of the literature

**Systematic Review**
- 27 studies, 18,273 patients
- 9 countries, 7 tumour types, 2 mixed cases

**Results**
- 4%-45% change in diagnostic reports
- more likely to have more complete pre-operative staging
- more likely to receive neoadjuvant/adjuvant treatment

**BUT...**
- limited evidence for improved survival/outcomes
- MDTM-survival benefit: 4 no association²/2 association³/4
- quality of studies selection bias/historical cohorts

---

**MDTs in real world**

Streamlining multidisciplinary team meetings

**Aims of cancer service reform**

1. Reduce variation in outcomes across England
2. Change England's international position

**Aims of MDTM reform**

1. Standard management transparency
2. Audit/benchmarking to measure adherence-outcomes
3. MDTM to operate more effectively in relation to:
   - Time
   - Human resources
   - Data collection
   - Decision making
Streamlining multidisciplinary team meetings

Consultation

Professional Associations

British Association of Surgical Oncology
Association of Cancer Physicians
Faculty of Radiology
British Society for Haematology
British Society of Gastroenterology
British Association of Paediatric Oncologists
British Association of Geriatric Surgeons
British Thoracic Oncology Group
Society for Cardiovascular Surgery
British Thoracic Society
UK Thoracic Group
Association of Breast Surgeons
British Society of Gynaecological Surgeons
British Society of Radiologists
Association of Upper Gastrointestinal Surgeons
British Urological Society
The British Association of Nephrology
British Thyroid Association
British Association of Urological Surgeons
Royal College of Surgeons

National bodies
Royal College of Physicians
Royal College of Surgeons
Royal College of Radiologists
Royal College of Physicians of Ireland
Chief of the Cancer National Programme of Care Board
National Clinical Director for Cancer
National Clinical Director for Cancer and Kings College Hospital
National Cancer Research Network of the Joint Clinical Director of Cancer Alliance/Vanguard

Individuals
Individuals identified in the notes of clinical directors and other relevant clinical leads

Streamlining multidisciplinary team meetings

Prioritising/stratifying patient discussions at multidisciplinary team meetings:

- Spending more time discussing patients with complex clinical or other issues - strata patients
  1. Patient on pre-determined management plan, no discussion
  2. Patient requires detailed and complex discussion

Patient stratified by their consultant in advance of MDTM
All patients accounted for

Developing prospective management pathways

1. Tumour site teams identify patient cohorts suitable for prospective identification of management pathways
   (not a one-size-fits-all tumour types or patients)
2. Cancer Alliance lead governance and approval of management pathways at regional level
3. Management pathways embedded across the Alliance geography
   - All patients on a locally agreed prospective pathway
   - Must be listed at the main MDTM
   - No patient is removed from oversight of the MDTM or responsibility of the MDTM

Managing prospective management pathways

Advantages of agreed management pathways

- Agreed best treatment
- Prospective recording of agreed best treatment
- Forces essential data to be thought about and recorded
- Faster time to treatment
- Variability easily identified by flagging patients discussed, YES/NO
- efficiencies for radiologists and pathologists
- Allows easy audit and benchmarking through NCRI/SACT database

NCRAS = National Cancer Registry and Analysis Service
SACT = Systemic Anti-Cancer Therapy Dataset
Concerns about statements in consultation document

- MDT
- Audit, more resource
- 'back to the old days'
  (younger consultants over reliance on MUTM)
- Outsourced imaging
- One-size fits all model
- All cancer cases need to go through an MDT at least once
- Educational importance
- Support for younger health professionals

"The MDT must not be used as an ‘X-ray meeting’ or ‘pathology meeting’. Images and histopathology are not to be reviewed’ at MDTM. Separate or sequential meetings must be set aside for such activity"

"Accountability for any intervention remains with the clinician responsible for that intervention"

Implementing audit of prospective pathways

1. Audit of MDTM is central to assurance of standards
2. Audit will be used to benchmark
3. MDTMs should review ‘listed’ patients quarterly
4. Process/outcomes documented and reported to the Cancer Alliance

Topics for inclusion in audits:
- Suitability of management selected
- Adherence to the management pathway
- Completeness of minimum data set
- Imaging and pathology results and decision to assign to pathway
- Clinical trial uptake
- Patient feedback (if available)
- Impact of the triage meeting on staff time (if there is one)

NEXT STEPS

Take proposals through NHS England
(Specialist Commissioning, Peer Review, Cancer Transformation Board)

Identify Alliances and pilot sites

Publish guidance incorporating findings from pilot sites

Transforming Multidisciplinary Team Meetings

Bottom line

Currently
1. Patients are not being discussed properly
2. Outcomes still poor in comparison to others after 20 years
3. Choice of treatment currently controlled
4. No audit of inconsistent judgements

Future
1. Anybody can post any patient for discussion for any reason
2. All patients will be in plain sight
3. Assurance of imaging/pathology is ‘listed’ patients
4. Audit easier because of minimum data sets
5. MDT accountability/responsibility will not change
<table>
<thead>
<tr>
<th>Name of Meeting:</th>
<th>Greater Manchester Cancer Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Meeting:</td>
<td>13th July 2018</td>
</tr>
<tr>
<td>Title of paper:</td>
<td>Macmillan Cancer Support Strategy Update</td>
</tr>
<tr>
<td>Purpose of the paper:</td>
<td>To articulate Macmillan Cancer Support’s strategy, priorities, and expertise, and to provide an overview of how Macmillan can contribute to cancer care and support in Greater Manchester.</td>
</tr>
</tbody>
</table>

**Reason for Paper:**
- [ ] Decision
- [ ] Discussion
- [ ] For Information

**Impact**
- Please state how the paper impacts on:
  - **Improved patient outcomes**: People living with cancer and their carers will have improved cancer care and will be better supported. We aim to support everyone living with cancer live life as fully as they can.
  - **Improved patient experience**: By working in partnership and co-producing new services with service users, we will ensure that services are designed and implemented in response to the needs of individuals.
  - **Reducing inequality**: In order to reduce inequalities, we have prioritised the development of an engagement and volunteering model that includes marginalised communities.
  - **Minimising variation**: Collaboration with our partners is key in order for Macmillan to understand the local needs and explore innovative ways of working to reduce variation.
  - **Operational / financial efficiency**: Macmillan can bring expertise, evidence and insight, and funding to support innovation and service development. We can also provide comprehensive service evaluations to support new ways of working.

**Author of paper and contact details**
Jane Melvin, Macmillan Head of Services, North West England:
jamelvin@macmillan.org.uk
07715813183
Purpose of paper

This paper compliments the presentation that will be delivered by Fay Scullion at the Board meeting on 13th July 2018. It provides an overview of Macmillan’s strategy and priorities; it also outlines how Macmillan can support Greater Manchester Cancer in the delivery of its Plan.

Our History

Douglas Macmillan established the ‘Society for the Prevention and Relief of Cancer’ in 1911. Since then, through the funding of the first Macmillan nurse in 1975 and the launch of our integrated phone support service in 2009, we’ve been established as an expert in cancer care and support.

As part of our strategy we aim to be a strong voice for change that people will listen to. Our history and the expertise we have developed over the years help us drive our strategy because they establish our credibility.

Who We Are

We are a team of supporters, volunteers, staff, campaigners, health and social care professionals, and fundraisers. We are cancer experts, an independent voice for change, and the name everyone thinks of first when cancer support issues are raised. Notwithstanding this, the most important things that bind us are our care and support for people living with cancer.

Our Purpose

Our purpose is to help everyone living with cancer live life as fully as they can. To achieve this, we need to make sure that our precious resources are used as effectively as possible, so that we can benefit as many people as possible.

That is why we have created a strategy that is based on our knowledge and expertise in cancer issues and the needs of people living with cancer. This will be the foundation for innovative approaches that enable us to invest effectively, with a view to developing the services that people living with cancer need.
Using Evidence
We are a recognised authority on cancer and related issues because we base all our work on evidence and insight. From individual service evaluations to major academic research, we back up everything we do: strategy decisions, service developments, policy calls, and our influencing work. Market research and insight also ensure that we communicate with people living with cancer, decision makers, and our supporters in the right way and at the right time.

Innovation and Service Design
As the challenges surrounding cancer care continue to increase and the healthcare sector struggles to cope, we need to think differently; we need to be innovative to make sure that we meet the changing needs of people living with cancer, both now and for the future. So, we will champion new ways of re-designing the cancer care system, develop new roles, explore new services and introduce new ways of working.

Macmillan’s National Strategy
We want everyone with cancer to know we are there to support them from the moment they are diagnosed. By treating them as a person with a life and not just a disease, we will make sure that they are prepared for whatever comes next.

Our strategy sets out how we are going to reach and support more people living with cancer in the future. To develop our strategy, we considered the following:

- The needs of people living with cancer, so that we can focus our efforts in the right places.
- What we can deliver and what other organisations might be better placed to do.
- How we can create a sustainable way of funding our work.

Our research highlights that people living with cancer need more than just medical support. It also shows that there are specific times when people with cancer need us the most and expect us to be there for them. Based on this, we have developed a strategy that focuses on five key times of need. Below is a high-level overview of our strategy:
Macmillan in the North West

The Macmillan NW geography covers South Cumbria, Lancashire, Greater Manchester, Cheshire, Merseyside and the Isle of Man. The geography, with a population of circa 7 million accounting for 11% of the total UK population, has a mix of urban and rural population settings and includes two major cities, Manchester and Liverpool.

The North-West Geographic Strategy

We have also developed a more localised strategy for each of our nine geographies. These are aligned to our national strategy and are based on local evidence. They allow us to prioritise, plan, and implement our support activities to meet the needs of people living with cancer in each geography.

There are six priorities in the North-West strategy:

- To improve the experience of people with treatable but not curable cancer into end of life.
- To influence and improve Primary and Community Care.
- To improve patient experience at the point of diagnosis.
- To influence and support the learning, development and sustainability of the cancer workforce.
- To implement and monitor the roll-out of the recovery package.
- To build a model of engagement and volunteering including marginalised communities.

The North-West Strategic Priorities are fully aligned to the Greater Manchester Cancer Plan, as shown in the picture below:

We recognise that by working with our partners to deliver our strategy, we will improve the system for people living with cancer and create innovative new services that help change people's lives, now and in the future.
Recommendations

The Greater Manchester Cancer Board is asked to:

3. Recognise the significant contribution Macmillan Cancer Support can bring to Greater Manchester.
4. To support working in partnership with Macmillan Cancer Support.
5. To consider adding a representative from Macmillan to the membership of the Greater Manchester Cancer Board.

Contact
Jane Melvin, Macmillan Head of Services, North West England: jamelvin@macmillan.org.uk

Julie Atkin-Ward, Macmillan Strategic Partnership Manager, Greater Manchester and East Cheshire: jatkin@macmillan.org.uk

Tanya Humphreys, Macmillan Services Programme Manager, North West England: tahumphreys@macmillan.org.uk
**Title of paper:** Details of priority one projects in phase 1 of Greater Manchester Cancer bid for Transformation funding agreed in May 2018.

**Purpose of the paper:** To inform the board of the agreed Transformation funding investment from the Greater Manchester Health and Social Care Partnership to begin the implementation key projects outlined in priority 1 bid.

**Reason for Paper:** Please tick appropriate box

| ☐ | Decision |
| ☐ | Discussion |
| ✓ | For Information |

**Impact**

Please state how the paper impacts on:

**Improved patient outcomes**

The priority 1 projects are aligned with the GM Cancer Plan objectives to improving patient outcomes, reduce variation and improving patient experience. These projects are the ones identified which specifically tackle the NHS planning guidance ‘must do’s for cancer, and other projects with a high impact for the investment, recognising the need to address the whole pathway of care: EG

- Accelerated pathway in lung, prostate and colorectal cancer
- CURE smoking Programme in secondary Care
- ERAS+ and recovery package/ stratified FU
- I-Can shared decision making in advanced disease

**Improved patient experience**

The priority 1 projects will be aligned with the User Involvement (UI) programme of work and ensure patient experience/ UI is a key outcome measure.

**Reducing inequality**

Components within the priority 1 projects are specifically targeted at addressing inequalities and providing access to populations in Greater Manchester based on need.

**Minimising variation**

The priority 1 projects are aligned with the core principle of reducing variation in Cancer Care across Greater Manchester.

**Operational / financial efficiency**

The implementation of the priority 1 projects, outlined in the GM Cancer plan, will create a net improvement in financial efficiency, through rapid diagnosis and supporting Cancer waiting times. Priority One projects also demonstrate key performance indicator including reduction in length of stay and re-admissions and reduction in aftercare/ Follow up appointments through stratified pathways.

**Author of paper and contact details**

**Name:** Claire O’Rourke  
**Title:** Associate Director at Greater Manchester Cancer  
**Email:** Claire.orourke@christie.nhs.uk
Greater Manchester Cancer Board

Date: 13\textsuperscript{th} July 2018

Title: Transformation funding bid: Outline of Priority 1 projects

Purpose of paper

This paper provides an update to the Greater Manchester Cancer Board regarding the successful bid to Greater Manchester Health and Social Care partnership (GMH&SCP) for Transformation funding investment to support the delivery of Priority One projects identified as aligned to the key objectives of the Greater Manchester (GM) Cancer Plan. The requested investment comprised of two key funding elements:

- Investment to support programmes of work and priority one projects identified within the GM Cancer Plan
- Investment to sustain the Greater Manchester Cancer core team through the entirety of the Cancer plan.

Recommendations

The GM Cancer Board is asked to:

1. Approve the paper and agreed funding plan allocated to priority 1 projects approved at the Health and Social Care Board (March 2018 – see attached paper for information) and GM H&SCP Transformation Fund Oversight Group (TFOG) (June 2018)
2. Agree an oversight and governance function around the delivery of priority 1 projects
Introduction:

The Agree projects outlined in the Transformation Fund Oversight Group (TFOG) bid in June 2018 are all aligned with the **6 headline ambitions** set out in the GM Cancer Plan 2017-21 and the NHS planning guidance 2017–2019:

- We will reduce adult smoking rates to 13%
- We will increase 1-year survival to 75%
- We will prevent 1300 avoidable cancer deaths
- We will offer class-leading patient experience consistently achieving over 9/10 in the National Cancer patient Experience Survey from 2018
- We will consistently exceed the national target for starting treatment within 62 days of an urgent cancer referral
- We will ensure the recovery package is available to all patients reaching completion of treatment by 2019

The GM Cancer Plan contains a high-level summary of the ambition for cancer in GM and represents a detailed plan for improved cancer care in a devolved GM and how these ambitions will be delivered.

Following the establishment of the GM Cancer Board and the 20 clinical cancer pathway boards that work with GM Cancer, the focus must be on the whole cancer pathway, with an increasing emphasis on early detection and faster diagnosis and living with and beyond cancer.

**The priority 1 projects** are aligned with the Taking Charge themes and also with a number of cross-cutting GM programmes that are being orchestrated by the Partnership, but delivered within and across localities of which **Cancer is a priority**:
Priority 1 projects have been chosen from the broader GM Cancer plan as these projects are an intrinsically linked to planning guidance requirements and have particularly high impact for the investment and have been agreed at the Health and Social Care Board (March 2018). Link to paper: Update Cancer Work - GMHC Board 16 03 2018: 08 - Update on Cancer Work - GMHC Board 16 03 2018 - FINAL - v1.0 (3).pdf. See papers for information attached to Board pack.

All priority 1 projects will be developed/ coproduced/ delivered with the GM Cancer Users Involvement programme, to ensure that patients and carers play a pivotal role alongside health professionals in shaping cancer services in GM and delivery of these projects.

The Priority 1 projects are:

- **Accelerated Cancer Pathways (Lung, Colorectal and Prostate)**

These accelerated pathways substantially cut cancer waiting times down by using same day and often shared diagnostics between providers, same day 'hot' reporting of tests, the use of 'pathway navigators' and streamlined MDT meetings. During the implementation and embedding of these accelerated pathways locally, we will adopt the models to improve the pathways in other cancers. The operational delivery of these pathways is our highest priority as our patients say that delay in diagnosis and treatment is their biggest concern.

It is anticipated that the accelerated pathways will cut time of diagnosis / treatment by 7-10 days per pathway. As these pathways are large volume in terms of patient numbers, it is expected these projects will make a material difference to the GM system’s 62d performance.

Lung Cancer is one of the key accelerated pathway as preliminary analysis of the impact in lung cancer in GM suggests that moving from the 62 day referral to treatment pathway to a 28 day pathway could save 200 lives per year due to earlier diagnosis and quicker treatment. Lung cancer remains the biggest cause of premature death in GM (data showed for premature deaths in GM 2011-13):
The accelerated pathways will support on-going and improved delivery against the **62 day standard** remains a core priority in GM, these programmes of work need to be prioritised to ensure those with the most impact are delivered first

- **Recovery package and Enhanced recovery after surgery (ERAS) plus:**
  GM cancer will be leading in the UK on the first project combining recovery package (RP) and Enhanced recovery after surgery (ERAS), to offer cancer patients in GM a bespoke package of care to prepare them for surgery, chemotherapy and radiotherapy treatment and to provide lifestyle and health promotion advice from the moment they are diagnosed, through treatment and into community services.

We have recognised that to improve recovery from cancer treatment, there needs to be prior optimisation of the patient (ERAS+ or ‘pre-hab’) in addition to an effective ‘recovery package’.

Developed alongside their cancer care team, the RP and ERAS combined programme will provides a comprehensive plan optimising recovery that not only outlines their physical needs but also identifies other support they may require including help at home, psychological and financial advice. Implementation of the RP and ERAS programme will require considerable coordination across the system and is a current high priority, particularly in cancers groups such as colorectal and lung cancer. Once in place, it facilitates bespoke after care arrangements and other improvements to care.

- **CURE secondary care programme:**

Eighty to ninety per cent of lung cancer cases are caused by smoking. Additionally smoking has a significant impact risk of other cancers (causing 20% of cancers in total). An effective tobacco plan is pivotal then to cancer survival and incidence. Perhaps more than any other intervention, an effective tobacco plan has the potential to genuinely transform cancer incidence and outcomes.

Smoking rates in GM are still approximately 2% higher in GM compared to England. Smoking related deaths in GM are the highest in England at 471.6 per 100,000 (significantly higher than the England average 288.7 per 100,000). The case for investment in tobacco control to reduce the cancer burden is especially important therefore in GM.

With a target to reduce adult smoking rates to 13% by 2020, more interventions are needed to encourage and support people to quit smoking.

The aim of the **CURE programme**, in collaboration with the Population Health Team at GM H&SCP, is to pilot a fully smoke free NHS service in GM, focussing on secondary care, with the first pilot site being Wythenshawe hospital. This will be the first such programme in the UK. The plan is based on a successful published city-wide trial in Ottawa where hugely beneficial outcomes were demonstrated.

The key aims of CURE are:
- The systematic identification and documentation of all smokers admitted to hospital
- The systematic administration of pharmacotherapy & behavioural support to active smokers in hospital

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The systematic attachment to long term community follow-up services after discharge.

This project intends to support rollout of the CURE Programme for inpatients across all acute providers in GM, learning from the pilot outcomes and replicating the expected improvement in patient outcomes and mortality rates, and in reducing burden to the healthcare system.

The plan will be to inform future commissioning and contracting discussions on smoking cessation services in acute and primary care, to ensure the CURE model remains sustainable and supported. This project aims to have a very active tobacco smoking quit programme offered to all patients admitted to hospital and could lead to a 40% reduction in the risk of death at 2 years in this cohort.

- **Cancer Education Programme:**

Currently there is a fragmented and un-coordinated approach to the commissioning and delivery of cancer education across GM. This has led to inequalities in access across the system, which contributes to inequalities in care.

The aim of this project will be to work with all stakeholders across the GM H&SCP (in health & social, voluntary, charitable and community), to create a single agreed educational vision for cancer workforce development and a single service framework for cancer education, as a trailblazer for the NHS nationally and supporting the delivery of priority 1 projects.

It will provide a mechanism for delivery of a transformational education programme which is accessible, innovative, comprehensive, effective and affordable; aimed at the whole cancer workforce and supporting all education commissioners and providers of cancer education across GMHSCP. It is expected that the programme will lead work in psychology offerings to patients (by training staff) and also support primary care by enhancing the GATEWAY C programme.

- **Shared decision making for Cancer patients-Can Guide:**

This programme of work, called ‘Can-GUIDE’, incorporates earlier Vanguard work (2016-2018) that developed and pilot tested a Goals of Care Initiative (GOCI) tool, followed by the development and piloting of a web-based patient-centred decision support package for adults with progressing cancer.

Approximately 57% of chemotherapy is prescribed with palliative intent; representing a significant number of people faced with complex decision-making. A major limitation to decision-making based solely on risk prediction models and survival outcomes is a lack of consideration for patient/family needs, goals and preferences.

Shared decision-making is defined as a person-centred, collaborative process that enables individuals and healthcare providers to make decisions together and more explicitly expands focus from quantity of life only to clearly consider quality of life. It can also lead to a reduction in the number of treatments given to patients through this shared decision making model.

This priority one project will focus on enhanced patient decision making, underpinned by goals of care discussion between patient/family and clinician, in the context of palliative chemotherapy. Its impact, based on a pilot, is expected to be profound in terms of avoiding unnecessary and costly treatments, making difficult discussions easier.
- **Cancer Intelligence:**

Cancer data and dashboards that are nationally available, have significant limitations in what they can provide at the System and clinician/patient level for GM. National systems and dashboards are useful for high level measures and the identification of outliers compared to other regions and the England average, but less useful for intra-regional and small area comparisons and are unable to provide the level of intelligence needed to explain variation or support strategies for change.

The purpose of the GM Cancer Intelligence Service (CIS) is to provide commissioners and providers and GPs, access to the most current and detailed performance, outcomes and patient experience data as possible, to help support cancer services and the delivery of the GM Cancer Plan by 2021. The service will also provide access to meaningful data for patients to help inform their choices related to their cancer care.

By providing cancer intelligence both at system, and at service / clinically relevant patient cohort level, the service will enable commissioners and providers to identify both best practice and progress against achievement of the cancer plan objectives. The service will provide intelligence to help clinical pathway boards identify where improvements/service redesign would be beneficial to improve performance and outcomes and meet the cancer plan objectives. One example is for the service to provide a dashboard of diagnostic waits and cancer waiting times between providers to improve transparency and shared working.

- **Stratified follow up:**

The Vanguard pilot in GM began testing and developing stratified models of care and support that evaluates holistic patient needs, in addition to the needs of the disease or treatment received. Priority pathways include breast, colorectal & prostate patients, as around 50-70% of breast, 50% colorectal and 30% prostate patients are estimated to be suitable for supported self-management, requiring only imaging or biochemical surveillance and patient initiated contact as required. This project will support the Recovery Package and ERAS+ projects.

This priority 1 project will reduce the demand for routine follow up, and release capacity to address the expected increase in patient numbers. Evidence from the vanguard pilot identified that 68% of patients on the new breast aftercare programme were assessed as suitable for self-management. 95% were satisfied with their new ‘moving on’ appointments and the information and advice given at these, and focus groups established that patients felt the new programme encouraged self-management and self-monitoring. Key benefits to the system and patients are:

- Many out-patient follow up appointments offer little value to the patient. Large proportions are scheduled simply to convey a test result.
- Demand for cancer outpatient appointments is increasing by three per cent per year due to increased incidence and improved survival rates. Additional resources are not available to meet this increasing demand.
- Needs change as patients move along the pathway demanding a more tailored approach to care in place of the current ‘one size fits all’ approach.
- Released capacity enables resources to be redistributed to diagnosing more new patients and supporting those with metastatic and complex disease.
The personal cost of follow-up can be significant for patients particularly those with other conditions and illnesses who need to attend other departments. Where the patient cost of care can be reduced it should be.

Technology is offering many new alternatives to face-to-face follow up. Existing clinics are often overbooked and ensuring access times for new patients and urgent follow ups can be challenging.

**Funding agreed at TFOG:**

The bid to TFOG requested funding towards the priority 1 projects of the GM Cancer Plan. The eight projects identified will cost £13.5m over the three year period 2018-2021. A contribution of £10m is requested from the Transformation Fund and this will be supported by a minimum of £3.5m of external funding sources.

A summary of each of the priority 1 projects is provided below the cost of each project over the three years to 2021 is forecast to be:

<table>
<thead>
<tr>
<th>Priority 1 areas</th>
<th>3 year cost to 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core infrastructure</td>
<td>£3.37</td>
</tr>
<tr>
<td>Accelerated pathways</td>
<td>3.75</td>
</tr>
<tr>
<td>Recovery package/ ERAS</td>
<td>1.68</td>
</tr>
<tr>
<td>CURE smoking programme</td>
<td>1.88</td>
</tr>
<tr>
<td>Education</td>
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<td>CAN guide</td>
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<tr>
<td>Cancer Intelligence</td>
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<tr>
<td>Stratified follow-up</td>
<td>0.75</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13.5</strong></td>
</tr>
</tbody>
</table>

The work undertaken by GM Cancer to assess the evidence base supporting each of the individual projects has resulted in some conservative estimates of lives saved, treatments averted and cases of earlier stage diagnosis. Up to 2021, the full delivery of the 8 projects that make up the priority 1 areas of the GM Cancer Plan will deliver:

- Lives saved 825
- Treatments averted 2,310
- Earlier stage diagnosis 225

In calculating the net present budget impact, savings have been attributed to treatments averted and earlier stage diagnosis as these will be of direct benefit to the health system. No assumptions have been made about any wider economic benefit associated with lives saved.
It is important to note that further bids to the GM Transformation fund will be made in future to secure much needed additional and significant investment to deliver the rest of the GM Cancer plan. It is proposed that these will be worked up through the GM Cancer Board and include broad discussion with stakeholders in the coming few months.

**Investment panel:**

The detail of each project (given the funding envelope already agreed) will be subject to scrutiny by a GM Cancer Board investment panel (to be configured). A process for formal detailed oversight of each project once live needs to be described.

**Timelines for funding approval:**

<table>
<thead>
<tr>
<th>Greater Manchester Cancer Investment and funding plan</th>
<th>Date of approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper to GM cancer board outlining investment proposals:</td>
<td>7th February 2018</td>
</tr>
<tr>
<td>Greater Manchester Cancer paper and presentation approved at Health Care board:</td>
<td>6th March 2018</td>
</tr>
<tr>
<td>First Greater Manchester Cancer Transformation funding bid submitted.</td>
<td>30th April 2018</td>
</tr>
<tr>
<td>Final Greater Manchester Cancer Funding bid approval at TFOG</td>
<td>12th June 2018</td>
</tr>
<tr>
<td>Approval at Executive Strategic Partnership Board at the Health and Social Care partnership</td>
<td>21st June 2018</td>
</tr>
<tr>
<td>Agreement of funding plan at GM Cancer board for Priority One Projects aligned with the Greater Manchester Cancer plan.</td>
<td>13th July 2018</td>
</tr>
</tbody>
</table>

**Conclusion:**

Approval of priority 1 projects outlined about will allow GM cancer and the cancer system in GM to continue to deliver on key objectives set out in the GM cancer plan 2017.

Reporting to the GM Cancer Board, a Programme Board for delivery will be established to monitor progress in implementing the priority 1 projects against plan and this will receive reports from the individual project boards charged with the implementation of each priority 1 project. In parallel to this, GM Cancer Senior Management Team will provide day to day leadership and direction to each project team.

Claire O’Rourke  
Associate Director Greater Manchester Cancer  
13/07/18.
Greater Manchester Cancer Board

Date: 13th July 2018
Title: Great Manchester and Eastern Cheshire Acute Oncology Update
From:
- Dr Claire Mitchell, Clinical Director, Greater Manchester Cancer Acute Oncology Pathway Board - Claire.Mitchell@christie.nhs.uk
- Sue Sykes, Programme Manager, Greater Manchester Cancer Commissioning Programme – susansykes@nhs.net

Purpose of paper:
This paper is intended to update the Greater Manchester Cancer Board on further progress with the development of a Greater Manchester and Eastern Cheshire wide commissioning service specification and development of delivery models for Acute Oncology.

The draft Greater Manchester and Eastern Cheshire Acute Oncology commissioning service specification sets out the indicative standards and outcomes that the Greater Manchester and Eastern Cheshire acute oncology teams should provide. The specification remains in draft until formally approved through the governance arrangements outlined below. However the clinical standards outcome and performance measures were ratified by the Greater Manchester Cancer Acute Oncology Pathway Board during February – April 2018 and by the Greater Manchester Cancer Board in May 2018.

The Greater Manchester Cancer Board is asked to:
- Note the progress made to date and acknowledge the planned work over the coming months.

Progress to date:
The Greater Manchester Cancer Board in July 2017 recognised the role acute oncology plays in the management of patients with complications of their current diagnosis, treatment and the management of patients with an acute new cancer diagnosis. The Board acknowledged the current inequalities and variation in outcomes, experience and delivery across Greater Manchester and Eastern Cheshire. The Board agreed to the development of an acute oncology commissioning service specification and delivery model in line with the recommendations outlined by Dr Claire Mitchell, Pathway Director Acute Oncology, Greater Manchester Cancer; which meet the objectives within the Greater Manchester Cancer Plan 2017 - 2021.

Since July 2017 the following progress has been made:
- A Greater Manchester and Eastern Cheshire Acute Oncology Commissioning Task and Finish Group was established in September 2017, chaired by Adrian Hackney, Director of Cancer Commissioning, and Greater Manchester Commissioning Hub.
• The group had clinical and commissioning representation from acute oncology, urgent and ambulatory care, enhanced supportive and palliative care; primary, secondary and tertiary care; the Greater Manchester Cancer User Involvement Team and People Affected by Cancer.

• The Task and Finish Group met formally over the period October 2017 to February 2018. A governance model and delivery timetable was developed and agreement to the service specification identifying and outlining:
  o Why the case for change is required.
  o What the service needs to deliver.
  o What the clinical standards, outcome and performance measures are in order to provide a Greater Manchester and Eastern Cheshire acute oncology service fit for the future.
  o Baseline review of current service provision.
  o In collaboration with the Greater Manchester Acute Oncology Pathway Board a set of indicative clinical standards, outcome and performance measures have been developed which are in line with national guidance.

• The clinical standards outcome and performance measures were ratified by the Greater Manchester Cancer Acute Oncology Pathway Board during February–April 2018 and by the Greater Manchester Cancer Board in May 2018.

• The Greater Manchester Commissioning Cancer Programme Manager has ensured all CCG Cancer Commissioning leads have been kept informed of progress to ensure strategic alignment at locality level.

• In May 2018 the Greater Manchester Cancer Board acknowledged that the draft specification requires further work to develop a formal business case for future service provision and secure Provider Trust, CCG and Joint Commissioning Board support. Members agreed that this future work would be overseen by Mr. Dave Shackley, Medical Director, Greater Manchester Cancer and Fiona Noden, Chief Operating Officer, Christie NHS Foundation Trust.

Progress since May 2018:
A Greater Manchester Cancer Acute Oncology Task and Finish Group has been established, who met for the first time on the 25th June 2018. The process the group will undertake supported by a dedicated project manager will be as follows:
• Assessment of current provider position against the clinical standards.
• Meetings with localities to discuss / identify current models and any gaps in service provision and achievement against the clinical standards.
• Identification and costing of delivery models to meet the clinical standards.
• Development of an options appraisal and cost benefit analysis.
• Testing of models and analysis with localities and providers.
• Refinement of models.
• Presentation of business case with a proposed model to all required governance groups including Greater Manchester Cancer Board, Greater Manchester Directors of Commissioning, Directors of Operations, Chief Finance Officers, Directors of Finance, Greater Manchester Provider Federation and CCG Chief Officers and the Greater Manchester Health and Social Care Joint Commissioning Board.
• Develop a plan for implementation of the agreed model.

Recommendation

The Greater Manchester Cancer Board is asked to:
• Note the progress made to date.
• Acknowledge and agree to the work planned over the next six months