GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Greater Manchester Cancer Board

Agenda

Meeting time and date: 8.00am-10am Friday 4th May 2018

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

Chair: Richard Preece.

#	Item	Type	To	Lead	Time
1	Welcome and apologies	Verbal	-	Richard Preece	5′
2	Minutes of the last meeting	Paper 1	Approve	Richard Preece	
3	Action log and matters arising	Paper 2	Note	Richard Preece	
4	Update from GM Cancer User Involvement Steering Group	presentation	Note	Sarah Haworth Nabila Farooq Ian Clayton	15′
5	Psychological support for Cancer patients: pathway board update	Paper 3 presentation	Note	Dr Padraig McDonnell	20’
6	Acute Oncology commissioning specification	Paper 4 presentation	Note	Dr Claire Mitchell	20’
7	Oesophago-Gastric (OG) Cancer Best practice pathway update	Presentation	Note	Dr Jonathan Vickers	20’
8	GM Cancer Commissioning update	Presentation	Approve	Rob Bellingham/ Adrian Hackney	20’
9	62 day cancer standard: ▪ New national waiting time guidance update ▪ Cancer leads meeting	verbal	Note	Fiona Noden/ Susi Penney	10’
10	GM Cancer Screening update: deferred-July 2018.		Approve	Jane Pilkington/ Christine Khiroya	
11	Cancer intelligence report	Paper 5	Note	Adrian Hackney	5’
12	Cancer Workforce strategy: Health Education England update	Presentation	Note	Dave Shackley	5’
13	Future Meeting Dates: ▪ **13th July 2018:** 8-10am ▪ **7th September 2018:** 8-10am ▪ **2nd November 2018:** 8-10am				

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Minutes of Greater Manchester Cancer Board

Time & date: **8.00am-10am Friday 9th March 2018**

Venue: **Frank Rifkin Lecture theatre, Mayo Building, SRFT.**

Chair: **Dr Richard Preece**

GM Health & Social Care Partnership Team		Richard Preece	RPre	Executive Lead for Quality, GMHSC Partnership (Chair)
AGG of CCGs		Rob Bellingham	RB	Managing Director, Association of GM CCGs
Provider Trusts	Salford	Jack Sharp	JS	Senior Manager
	Manchester FT	Darren Banks	BD	Director of Strategy
	Stockport	Helen Thomson	HT	Interim Chief Executive
	The Christie	Thomas Thornber	RS	Senior Manager
	Pennine Acute	Roger Prudham	RPRu	Deputy Medical Director
	Stockport	George Ogden (representing Tracey Vell)		GP lead
Person affected by Cancer		Nabilla Farooq	NF	_
User Involvement GM Cancer		Sarah Howarth	SH	Macmillan User Involvement Programme Manager
Eastern Cheshire CCG		Mike Clark	SR	GP Locality Peer Group Lead, Macclesfield
GM Cancer		David Shackley	DS	Medical Director, Greater Manchester Cancer
GM Cancer		Adrian Hackney	AH	Director of Commissioning – GM Cancer
Nursing Leadership		Dawn Pike	DP	Director of Nursing, MFT
Macmillan		Tanya Humphreys	TH	Programme Manager

In attendance

Lung Pathway presentation	Matt Evison	ME	Lung Pathway Director
Recovery Package Implementation update	Wendy Makin Lindsey Wilbey	WM LW	Living With & Beyond Cancer Director Living With & Beyond Cancer Programme Manager

GM Cancer	Susi Penney	SP	Head and Neck Pathway Director
	Claire O'Rourke	COR	GM Cancer
	Michelle Leach	ML	GM Cancer
	Ryan Donaghey	RD	Provider Federation Board
	Catherine Perry	CP	University of Manchester-RESPECT 21

1. **Welcome and apologies**

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

2. **Minutes of the last meeting**

DS noted a typing error on page 5, the rest of the minutes were signed off as being a true reflection of the meeting.

3. **Action log and matters arising**

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

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

NF thanked RPre for attending the user involvement away day and explained that they are developing their outcomes for the year as a result of this. Once this has been developed it will be reported back to the group.

5. **Greater Manchester Cancer: Lung Cancer Update**

- Optimal Lung Cancer Pathway

ME spoke in relation to the tabled paper. He explained that although there is a national lung cancer pathway GM had produced a regional version which went above and beyond the national pathway- instead of 49days time to treatment, in GM the standard would be 28 days.

A gap analysis had been produced to show the shortfalls and find a solution to allow implementation. He asked the group to note that access to diagnostics are an important part of this pathway and that shared access across the sectors and across GM is imperative to make this work.

RPre asked about the gaps in the data on the paper specifically the NW sector. ME explained that he hasn't yet received this data (which includes 3 major hospitals) JS from SRFT offered to help to provide this information.

RPre expressed concern about the origin of the numbers attached to the staffing ratio's on the paper. ME explained that they have come from NHS England and they are numbers being worked to nationally.

DB asked how commissioners can be involved in the work up to producing these pathways and how it can be future proofed. DS explained that we need input from commissioners and operational managers to work with ME to take this forward to become reality. AH stated that this now needs to be turned into a project to be delivered.

RPre thanked ME and the lung cancer pathway board on the work they have put in to date. To summarise he stated that the board is in support and asked ME to ensure the data is

provided from all sectors. This cannot be signed off today as all the information is not available but the board supports this moving forward and looks forward to seeing a progress report later in the year.

- CURE: secondary Care smoking prevention programme

ME explained to the group that this is a project about how we deal with tobacco addiction in secondary care. Smokers who are sick and in hospital are more open to consider stopping smoking (i.e. more 'teachable'). This will create positive health outcomes and cost savings to the system.

ME said that a huge culture change is needed to up skill all staff so they are able to deliver smoking cessation as part of their work followed up with specialist help after patients leave secondary care. Currently data is not available on this so this would need recording robustly. This could have a huge impact on the health of our population and in turn on the success of the cancer plan. Currently a 6 months pilot is being worked up to be carried out at Wythenshawe Hospital with the next steps once this has been completed being upscale and spread. RPre explained that this is going through the Population Health Board and funding will come from several partners. A discussion ensued about the metrics and the measurement plan attached to this across primary and secondary care.

6. Single Surgery Services in Cancer: Implementation Programme Update

OG – SMW explained that this programme of work is about transferring the work from MFT to SRFT. Resource is in place in the form of project management; a clinical pathway has been designed and signed off at the implementation board. Issues have been raised around on call Rota's this is now being moved forward to resolution.

Urology – KR presented as she leads on this programme. Like OG there is a challenge around on-call Rota's and how this impacts on benign urological disease which is in the process of being worked through. The Urology Pathway Board have produced prostate, kidney and bladder pathways. The next stage in this work is how the MDT's will be managed and there is a subgroup next week to start looking at this.

Gynae – SMW updated the group on this newer programme of work. SMW explained that MFT is lead provider and Christie is key provider, CoR offered to send round a paper to the group explaining the operational definitions of these terms. The first board met in December 2017. SMW spoke to the tabled milestone plan and explained it is a very complex programme of work involving significant change for gynecology colleagues.

DS spoke about the complications of looking at the urology Rota's and involving both benign and cancer colleagues. DB expressed that he feels that a model of care for benign disease needs to be produced and this will move this work forward. WM expressed the importance of executive teams being involved in this process as this will help to unblock any issues that arise. RPre thanked SMW and KR on behalf of the board for the update.

7. Recovery Package Implementation Update

WM presented on the elements of the Recovery Package and how this will equip patients to utilise supportive self-management. She explained that the target is that from March 2019 all aspects of the recovery package should be available to all patients. WM highlighted the challenges of delivering this and the resource implication involved. Progress had been good with engagement of all providers in both the Steering and Implementation Groups. The pathway boards have also supported this work, with PAbC involvement across all groups.

Next steps involve producing robust metrics which should be reported to the board around June, a funding plan and a contingency plan should funding not be available. DB asked about governance and partnership working between primary and secondary care. WM acknowledged there is a lot more work to be done to strengthen these partnerships.

RPre said that he will make a connection between the LCO group and secondary care to help enable this partnership working. The board acknowledged that metrics and communications are key to his work moving forward.

A discussion ensued about the CNS input into the delivery of the Recovery Package and that it will take up a lot of their time in respect of delivering the HNA's and care plans. There is also disparity across the system in terms of the level they work to as they range from a band 6 to 8. The Chief Nurse group are carrying out a piece of work on this and will feedback on the nursing input and definition of CNS and what that looks like at a future meeting.

8. GM Cancer Commissioning update

RPre postponed until the next meeting as IC is not in attendance today and he raised issues around the finance paper and funding at the last meeting. RB suggested a meeting between commissioning colleagues and the UI programme prior to the next meeting to answer any queries. SH will facilitate this.

9. Process for Cancer Programmes accessing the GM Cancer fund

DS spoke about the tabled report. He explained that there will be an opportunity at this board to challenge the investment panel's recommendations. He explained that this will be a transparent process involving PAbC and other board representatives. The UI team welcomed the opportunity to be involved and the transparency attached to this.

10. Any other business

(i) PC - GM approach to PAbC living with pain. RP said a solution exists via the End of Life and Supportive Care Pathway Board and this topic was not for this group.

(ii) CoR - Information requested on cancer workforce plan. CoR explained that an email had been sent round to all Trusts to request provider level numbers for current staff & funded posts in each of the 7 key occupations outlined below and asked the provider representatives to ensure the information be returned by 16th March. To provide update at next GM cancer board.

- Histopathology – Medical
- Clinical and Medical Oncology – Medical
- Gastroenterology – Medical
- Clinical Radiology – Medical
- Diagnostic Radiography - Allied Health Professional
- Therapeutic Radiography - Allied Health Professional
- Additional profession / skills / role – optional

(iii) DB – Genomic Testing. Work is underway in bidding for Manchester to become a centre for Genomic Testing. To be brought back to the board as an agenda item in the near future.

(iv) DS – Terms of Reference. To be refreshed an brought back to the board once circulated to board members for ratification in July 2018.

(v) DS – Greater Manchester Cancer Conference. To take place 26th November at Emirates for approx. 300 people more information to be circulated in the near future.

11. Date of next meeting: Friday 4th May 2018: 8-10:00hrs

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

- **13th July 2018**
- **7th September 2018**
- **2nd November 2018**

Greater Manchester Cancer Board

Action log

Prepared for the 4th May 2018 meeting of the board

	ACTION	AGREED ON	STATUS
1	Review of Greater Manchester's SACT strategy to be conducted, co-producing a refined strategy. Meeting to be convened with CCG teams and providers	3rd November 2017	SACT Strategy to be circulated to relevant groups update **13th July 2018**
3	Acute oncology: commissioning service specification to be completed	3rd November 2017	Update for Acute oncology and Paper for GM cancer board **4th May 2018**
4	MDT reform: DS to report back to GM cancer board in July on progress on pilots	3rd November 2017	Paper for GM cancer board **13th July 2018**
5	It was agreed and confirmed that there would be a commissioning update, following meeting with User Involvement representatives	9th March 2018	Confirmed this would be an agenda Item **4th May 2018**
6	JP to provide an action plan and update on the screening to the GM Cancer board in May 2018.	12th January 2018	Paper GM board **13th July 2018**
7	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**
8	Cancer workforce review led by HEE: Update on outcomes of phase 1.	9th March 2018	Confirmed this would be an agenda Item **4th May 2018**

Agenda Item No: 5

Name of Meeting:	**Greater Manchester Cancer Board**	
Date of Meeting:	4th May 2018	
Title of paper:	Recommendations from Gap Analysis of psychological support services in cancer across the Greater Manchester (GM)system	
Purpose of the paper:	The purpose of this paper is to outline to the GM Cancer Board the gaps in a dedicated professional Psycho-Oncology services provision in cancer across the Greater Manchester Cancer hospital sites and how we can close these by providing a business case for change.	
Reason for Paper: *Please tick appropriate box*	✓	***Decision***
	☐	***Discussion***
	☐	***For information***
Impact	*Please state how the paper impacts on:*	
Improved patient outcomes **Improved patient experience** **Reducing inequality** **Minimising variation** **Operational / financial efficiency**	Psychological distress in cancer patients is a significant and on-going problem (see Macmillan: Developing Adult Professional Psychological Services for Oncology, 2015). Emotional and psychological long-term side effects of cancer and its treatment include depression, anxiety, memory problems, difficulty concentrating, sexual problems and reduced social skills. Although a certain amount of emotional distress is common, particularly around the time of a diagnosis, approximately 50% patients of experience levels of anxiety and depression severe enough to adversely affect their quality of life. By ensuring parity of psychological service across GM care providers we will improve patient experience and outcomes for all. It is estimated that 20% of healthcare costs can be saved in the long term by having trained psychological professionals embedded in cancer services.	
Author of paper and contact details	Name: Michelle Leach Title: Pathway Manager Email: Michelle.leach1@nhs.net Tel: 07825761275	

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Greater Manchester Cancer Board

Paper number 3

Date: 4th May 2018

Title: Gap Analysis of psychological care in cancer services

Presenter: Dr Padraig McDonnell – Clinical Director

Purpose of paper
To ask the board to support a business case to improve equity of access to specialist services with expertise in Psycho-Oncology within Greater Manchester (GM) care providers.

Background
Psychological distress in cancer patients is a significant and on-going problem. Emotional and psychological long-term side effects of cancer and its treatment include depression, anxiety, memory problems, difficulty concentrating, sexual problems and reduced social skills. Although a certain amount of emotional distress is common, particularly around the time of a diagnosis, approximately 50% of patients experience levels of anxiety and depression severe enough to adversely affect their quality of life.

The Psychological and Mental Health Pathway Board Clinical Director was tasked with identifying the level of service provision required to address inequities as well as support level 2 training needs and supervision. During August to September 2017 a template was shared with all providers in GM Cancer to complete a workforce and training needs assessment which informed a gap analysis. This highlighted the following:

- **There was NO equity of access to specialist services with expertise in psycho-oncology**
- The need to develop standards for psychological care
- The need to implement widely a tiered model of care, including training for key staff in 'psychological first-aid' (see table 1)
- Integrated care pathways with mental health care providers.

Table 1 - Tiered Model

Level 1	All health and social care professionals This level of expertise is acquired from pre-registration training. General adjustment issues related to the experience of receiving a diagnosis of cancer Recognise and acknowledge psychological distress
Level 2	Health and social care professionals with additional expertise Completion of advanced communication skills three day course plus attendance at a Network approved 2 day Level 2 course and on-going support from L3 or L4 staff. Mild mood and adjustment difficulties and screening for psychological distress
Level 3	Trained and accredited health and social care professionals Qualification in psychological therapy and accredited by a recognised counselling/psychological/ psychotherapy organisation e.g. BABCP, UKCP, BACP, BPS; or a registered mental health nurse with a diploma in counselling with full accreditation as above; or a social worker with additional university accredited clinical diploma in counselling or psychotherapy with full accreditation as above. Mild to moderate psychological distress and psychopathology associated with cancer and its treatment. Differentiating between moderate and severe levels of psychological need.
Level 4	Mental Health Specialists (in psychological support) e.g. Clinical Psychologists, Psychiatrists As Level 3 plus a recognised mental health qualification Severe and/or complex psychological difficulties resulting from a diagnosis of cancer Advanced psychological/psychiatric assessment and interventions It is the requirement of Levels 3 and 4 staff to develop and deliver training sessions to level 2 staff. This includes providing clinical supervision/reflective practice sessions and where patients present with difficult management issues, Levels 3 and 4 staff offer joint assessment and care planning.

Current Service provision:

NICE (2004) estimates that around 1 in 4 cancer patients will require expert psychological assessment and intervention (Level 3) as a result of their diagnosis and 1 in 10 will require care from a psychiatrist or clinical psychologist (Level 4). In addition to new cancer diagnoses improved survival rates and associated advances in medical management of cancer mean that people are living longer with a cancer diagnosis.

Table 2 - The number of new cancer diagnoses in GM Cancer during 2016/17 financial year (*provided from the cancer waiting time data set sourced from Open Exeter Portal and is post processed data)*

Number of New Diagnosis 2016/17	10% needing access to level 4 interventions	15% needing access to level 3 interventions	10% patients needing support with advanced disease
12940	*1294*	*1941*	*1294*

In addition to the above an estimate of 1 in 20 family members or carers who are supporting a relative going through cancer require access to a specialist psychological support service attached to the acute hospital caring for the person with cancer. This would equate approximately to an additional 650 new referrals per year across Greater Manchester and East Cheshire. The total number of new referrals per year requiring access to a specialist Psycho-Oncology service with professionals working at Level 3 and 4 is therefore 1294 + 1941 + 1294 + 650 = **5,179.**

Mapping work suggests a caseload of 150 new **patients** per annum per WTE level 3/4 practitioner Therefore, 5,179/150 = **34.5 WTE level 3/4 practitioners** needed to provide direct intervention plus further staff for Training/Supervision as detailed below.

A fundamental role of level 3 and 4 practitioners is the on-going support for level 2 providers. GM Cancer has an approximate total CNS workforce of **313** (as per workforce mapping conducted in 2017 by contacting Lead Cancer Nurses in each locality within GM Cancer). Supervision typically runs in groups of 4, meaning 80 monthly sessions of up to 1.5 hours are required in GM Cancer. The WTE of trained/qualified Psychological Professionals (working at Level 3/4) needed to ensure there is capacity to offer at least 80 supervision groups per month within GM Cancer is **0.9WTE** (calculation based on 42 weeks a year allowing for fixed leave periods such as annual leave/bank holidays).

Many of the weekly Cancer MDTS may require (or wish to include) a Level 3/4 psychological professional for consultation/case discussions and compliance with national recommendations around membership of the core MDT. Typically this would require at least 0.1WTE of each 1.0WTE acute hospital based post to be dedicated to attendance at cancer/specialist palliative care MDTs (not all will require weekly attendance). An additional resource of ***at least* 2.0WTE** would be required for this commitment to support MDTs.

Total requirement
The total GM Cancer level 3/4 requirement is therefore
34.5+0.9+2.0 = 37.4WTE
To fit with NCAT guidance, 60% of this should be level 3 i.e. 22.44WTE and 40% level 4 i.e. 14.96WTE

Table 3 – Established/Gaps in Psycho-Oncology Staff across GM Cancer Hospital Sites

Trust	**Current WTE at Level 4 (Clinical Psychology)**	**Current WTE at Level 3 (Counselling/CBT Therapists/Psychotherapists)**
Bolton	1.0WTE (Clinical Psychologist)	Required = 1.0WTE
MRI (MFT)	0.5WTE (Clinical Psychology into Haemato-Oncology Services only) Required = 0.5WTE to work across all tumour groups	0.2WTE (Psychotherapist in Haemato-Oncology services only) Required = 1.0WTE to work across all tumour groups
East Cheshire	Required = 0.5WTE	Required = 1.0WTE
Pennine Acute (Rochdale only) **NMGH/Fairfield/Oldham – no provision**	Cost-per-case available for PAHT patients (inc oncology) – – no dedicated WTE to Oncology Required = 1.0WTE	Cost-per-case available for PAHT patients (inc oncology) – no dedicated WTE to Oncology Required: 1.0WTE
Salford	0.8WTE (Clinical Psychologist - General Oncology) 1.9WTE (Clinical Psychology - Neuro-Oncology)	0.6WTE (Psychotherapist - General Oncology) 2.0WTE (Counsellor - Palliative counselling service)
Stockport	Required = 0.5WTE	Required = 1.0WTE
Tameside	Required = 0.5WTE	Required = 0.8WTE
Christie	1.1WTE (Consultant Psychiatrist in Psycho-Oncology) 0.4WTE(Clinical Psychologist)	1.9WTE (Counsellors/CBT/CAT Therapists in Psycho-Oncology)

Wythenshawe/Withington (MFT)	0.8WTE (Clinical Psychologist - Oncology)	0.4WTE (Counsellor - Macmillan Information & Support Service – additional volunteer counsellors will be available in 2018)
Wigan	Required = 1.0WTE	Required = 1.0WTE
Total (established and required)	6.5WTE established **4.0WTE required**	5.1WTE established **6.8WTE required**

Indicates where services exist but are limited and not offering equity of access to all tumour groups/localities.

Indicates where no specialist psycho-oncology service exists and what is required immediately based on the number of new cancer diagnoses for 2016/17.

Although the gap analysis indicates that an additional **25.8WTE** posts are required in total to support a gold standard service, immediate investment is sought to create appropriate referral pathways plus support for Level 2 staff (see localities highlighted in red in Table 3). A total of **10.8WTE are recommended therefore in the first instance** to provide parity across the system thus ensuring patient outcomes and experience are the same across the conurbation.

Where specialist psycho-oncology services are available they can also support the successful delivery of the Recovery Package including contributing to Health and Well Being Events, consultation to members of cancer/palliative care MDTs to support the effective use of E-HNAs/care plans where psychological or emotional concerns are identified (e.g. London E-HNA 2016 results – 30% of patients of patients completing E-HNA identified Worry, Fear or Anxiety as a concern as the top outcome). They can also support the delivery of a tiered model of care (Table 1); including training for key staff in 'psychological first-aid' as well as provision of specialist supervision for key staff (Level 2 providers of emotional support).

People affected by cancer have been instrumental in moving the work of this board forward. Initially formed as a subgroup of the Living with & beyond Cancer Board it was only in September 2017 after pressure from the GM Cancer User Involvement Steering group that the group became a board in its own right. At the recent user involvement away day a conversation café was held and Psychological Support came out 3rd as a priority ahead of the palliative care and the recovery package.

Key Partners:

- Local Mental Health Trusts delivering IAPT- LTHC pathways
- Third Sector/Charitable organisations e.g. Maggie's Centres, Beechwood Cancer Care, Bury Cancer Support
- Hospices/Bereavement Support services
- Macmillan User Involvement programme team (small community for Psychological Support)

Priority Actions to Improve Access to Psycho-Oncology Services within GM Cancer Care Providers:

- Seek immediate investment to ensure there are dedicated Psycho-Oncology staff working at each of the GM Cancer Hospital sites and remove any inequity of access that currently exists across the footprint of GM Cancer (in line with table 2).
- To ensure access to appropriate estates/equipment to perform roles i.e. private rooms for provision of psychological therapies, admin support, IT access etc.
- Ensure appropriate clinical governance is assured for all Psycho-Oncology staff e.g. clinical supervision, appropriate mandatory training etc. By working with colleagues in the development of the new Improving Access to Psychological Therapies (IAPT) system for Long Term Health Conditions (LTHC).

Recommendation to the Board:

That the board ask for a business case to be developed to support delivery of the key actions above.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Greater Manchester Cancer Board

Paper number **4**

Date: 4th May 2018

Title: Great Manchester and Eastern Cheshire Acute Oncology Update

From:
Dr Claire Mitchell, Clinical Director, Greater Manchester Cancer Acute Oncology Pathway Board
Sue Sykes, Cancer Programme Manager, Greater Manchester Commissioning Hub

Purpose of paper:
This paper is intended to inform the Greater Manchester Cancer Board on progress with the development of a Greater Manchester and Eastern Cheshire wide Commissioning Service Specification for Acute Oncology.

The Draft Greater Manchester and Eastern Cheshire Acute Oncology Commissioning Service Specification is attached to this paper. The draft commissioning service specification sets out the indicative standards and outcomes that the Greater Manchester and Eastern Cheshire acute oncology teams should aspire to.

The Greater Manchester Cancer Board is asked to:

- Note the progress made to date and acknowledge the planned work over the coming months.
- Review and comment on the draft commissioning service specification
- Acknowledge and agree to the work planned over the next six months

Progress to date:

In July 2017 Dr Claire Mitchell, Pathway Director Acute Oncology, Greater Manchester Cancer presented to the Greater Manchester Cancer Board an overview of the current provision of acute oncology services in Greater Manchester and Eastern Cheshire. The presentation outlined the current variation in outcomes, experience and delivery of services and made recommendations to the Board on the process by which the variation may be addressed.

The Greater Manchester Cancer Board 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; and 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 in the presentation; 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.
- The Task and Finish group chaired by Adrian Hackney, Director of Cancer Commissioning, Greater Manchester Commissioning Hub, included clinical and commissioning representatives from acute oncology, urgent and ambulatory care, enhanced supportive and palliative care; primary, secondary and tertiary care.
- A governance model and delivery timetable was developed and agreed.
- The Task and Finish Group met formally over the period October 2017 to February 2018.
- In October 2017 the group agreed that the service specification would identify and outline:
    - Why the case for change is required.
    - What the service needs to deliver.
    - What the quality measures and clinical standards are in order to provide a Greater Manchester and Eastern Cheshire acute oncology service fit for the future.
    - What the desired and required outcomes are.
    - Baseline review of current service provision.
    - Key performance measures by which the service will be measured against.
- In October 2017 the Greater Manchester Acute Oncology Pathway Board produced a set of clinical standards in line with NICE guidance, National Peer Review Programme measures and pathway agreed quality standards.
- In November 2017 an update paper was produced for the Greater Manchester Cancer Board and progress to date was noted.
- The Task and Finish Group further developed and agreed the clinical standards and throughout the process the Pathway Board has been consulted.
- Key Performance Measures and a Minimum Data Set have been developed and agreed by the Task and Finish Group, in discussion and consultation with Pathway Board members.
- The Acute Oncology Pathway Director and Pathway Manager in collaboration with all acute oncology teams have conducted a baseline review of current service provision.
- The Greater Manchester Commissioning Cancer Programme Manager representative has ensured all CCG Cancer Commissioning leads have been kept informed of progress to ensure strategic alignment at locality level.
- The clinical standards and key performance measures were agreed by the Pathway Board in February 2018 and formally endorsed in the April 2018 meeting.
- The draft commissioning service specification has been developed and this now completes phase 1 of the Greater Manchester Acute Oncology Delivery Plan (September 2017).

Next Steps

- To share the final draft of the commissioning service specification with members of the Greater Manchester Acute Oncology Pathway Board (Pathway Board meeting: 27 April 2018).
- To share the final draft of the commissioning service specification with all Greater Manchester CCG Cancer Commissioning leads (meeting 3rd May 2018).
- To seek and gain approval of the draft commissioning service specification and strategic direction from Greater Manchester Cancer Board (meeting 4th May 2018)
- Identify delivery models to achieve the standards, carry out an options appraisal and cost benefit analysis of the models. In order to carry out the second phase of the Greater Manchester Acute Oncology Delivery Plan the task and finish group will require dedicated project management support.
- Gain approval of the service specification and costed model from the Greater Manchester Cancer Board and the Greater Manchester governance arrangements outlined on page 1 of the commissioning service specification.
- Develop a plan for implementation of the agreed model.
- Implementation of chosen model by October 2018.

Recommendation

The Greater Manchester Cancer Board is asked to:

- Note the progress made to date.
- Review and comment on the draft commissioning service specification
- Acknowledge and agree to the work planned over the next six months

Contact:

- 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

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Paper number ***5***

Date: 27 April 2018

Title: Cancer Intelligence Service Project Update

From: Cancer Intelligence Service Team

Purpose of the paper
This paper outlines the progress that has been made so far in establishing a cancer intelligence service for GM Cancer

Recommendations
The GM Cancer Board is asked to note the contents of this report, note the progress made so far in each of the objectives, and support the planned delivery of those objectives to full implementation.

Contact
Catherine O'Hara, Principal Analyst, Cancer Intelligence Service for GMC
Catherine.ohara@christie.nhs.uk

Establishment of a cancer intelligence service for GM Cancer

Purpose of this document

The establishment of a Cancer Intelligence Service for GM Cancer was initiated as a Cancer Vanguard project in recognition of the need for more timely and locally targeted cancer intelligence to support the GM Cancer Plan.

The Project has three key objectives.

1) To create an interactive dashboard of metrics and reports mapped to the GM Cancer Plan objectives
2) To identify and access sources of local data that will enable cancer intelligence reporting to become more timely and more in sync with current cancer services activity.
3) To provide a responsive analytical service to support the needs of GM Cancer, undertaking exploratory and investigatory analysis into trends, variation and areas of inequality and providing data and intelligence as well as analytical and statistical support for evaluating the progress of all the GM Cancer improvement projects.

This paper outlines the progress made so far towards each objective.

Creating an interactive dashboard of metrics and reports mapped to the GM Cancer Plan objectives

The GMC Cancer Intelligence Portal is now live. Access can be requested by emailing **cancerintelligence.gmc@christie.nhs.uk.** Some screen shots of some of the reports are in the **appendix** below.

We are asking for feedback from all users on the accessibility of the portal and the content of the reports to try to improve the user experience and ensure the reports meet the needs of the whole GMC System. Further development will continue in response to feedback received.

Access to the Portal is currently restricted to NHS staff. Reports for **people affected by cancer** are still under development and we are currently assessing different options for the general public.

Access to each report within the portal can be individually restricted and access to each report will be determined by the respective data governance and access approvals dictated by the data source used for the report. Where necessary small numbers are suppressed to ensure data are non-disclosure.

The portal currently houses three reports accessible by everyone who has been allocated a login:

1) Cancer waiting times and performance metrics
2) Outcomes metrics and analysis
3) Metrics linked to the GM Cancer Plan.

Within each report are various sub-reports from different data sources related to a range of service and outcomes measures e.g. two-week waits, 62-day waiting times, 28-day targets, smoking, one year survival and stage at diagnosis.

We are also working on pathway specific reports and reports based on investigative analyses. These will be shared initially with the pathway groups before opening up to wider access. Already within the reports are interactive reports of all cause crude survival and time from referral to date of diagnosis (28 day targets) by CCG, pathway and stage at diagnosis.

These are analyses undertaken by the Cancer Intelligence Team using an extract for data provided by PHE.
These are **new analyses not currently available from any other national source**. Soon to be added are reports on stage at diagnosis by GP and pathway.

Risks to this objective
Our current access to the cancer waiting times data used in the dashboard is being stopped from May 2018 due to changes in data governance around these data. We have been granted access to aggregated reports but these reports are not compatible with the data structures we have built for the dashboard. With our Pan Vanguard informatics colleagues we are working with NHS Digital and the Cancer Programme to resolve this. The main issues are around the lack of legal basis of cancer alliances and NHS Digital wanting to apply small number suppression rules for any outputs produced which doesn't work for CWTs, given the small number of breaches.

Access to local data flows (see below) will help to overcome this issue as we will access the data directly via local data sharing agreements rather than through NHS Digital. These agreements are still in progress so there is likely to be a period of time from May 2018 when we are unable to report 62 days and other cancer waiting metrics via the dashboard.

Identifying and accessing sources of local data that will enable cancer intelligence reporting to become timelier and more in sync with current cancer services activity.

The best source of data for timely cancer intelligence is data already being collected and collated by each of the cancer service providers for mandatory national returns. These national returns already contain all of the data needed locally by GMC and are being submitted to NHS England and PHE on a monthly basis.

The intention is for each provider to share these data sets with GMC at the same time as they are submitted as national returns. This ensures there is no extra work or resource burden on the providers. Once received we will be able to link the records from each Provider into a single pathway record for each patient that will enable reporting around services and outcomes in a much more timely fashion than is available from nationally produced reports. These linked data sets will enable us to identify variation in times from referral to first appointment, to first diagnostics and to a definitive diagnosis and to first treatment. We will be able to identify geographic and pathway as well as patient demographic level variation in stage at diagnosis, treatment modality and outcomes. We will be able to provide metrics around early and late stage diagnosis for patients being diagnosed in the current quarter rather than for patients diagnosed 12 months ago as is currently the case with national reports.

Having access to local data flows via local data sharing agreements also protects us against national level changes to data governance and the reduction in access to national data sources as is currently occurring with the cancer waiting times data (as described above). Cancer Alliances currently do not have any legal status and this makes access to data problematic. Having our own local data sharing agreements in place will put us in a much more secure position for cancer intelligence than any of the other Alliances.

To enable the sharing of these data, we needed to get approval from NHS Digital which was initially obtained in February. Unfortunately NHS Digital has subsequently retracted that approval and has requested a different data sharing model. A new data sharing agreement has now been submitted to NHS Digital for approval.
Also, as requested by NHS Digital, we are setting up the required data processing agreements between the Christie (as host of the GMC Cancer Intelligence Service) and each of the CCGs. This is currently being worked on with help from The Christie IG leads.

In addition, the CCGs are each discussing this arrangement with their respective providers and agreements to share the data flows are being written into the CCG-Provider contracts.

The datasets will be shared with NHS England who will the data and then pass the data to us for processing.

To date Manchester CCG has completed their contract variances. Others have given verbal assurances that these are being done. Some CCGs still need to have the necessary discussions. We are in close contact with all CCGs to support them in this. We are expecting all contract variances to be completed within the next few weeks.

Risks to this objective

1) Not all CCGs-Providers agree to share their local data flows
2) NHS Digital reject our data sharing application
3) Not all CCGs accept our request to act as data processors on their behalf.

Providing a responsive analytical service to support the needs of GM Cancer, undertaking exploratory and investigatory analysis into trends, variation and areas of inequality and providing data and intelligence as well as analytical and statistical support for evaluating the progress GM Cancer service improvement projects.

This objective is already complete. The Cancer Intelligence Team is made up of a small team of highly qualified and experienced statisticians and business intelligence analysts who are working on pulling all available data together for analysis and intelligence reporting. An interactive dashboard has been built that delivers a central location for all nationally reported data, presented in ways that reflects the needs of the GMC System as well as access to intelligence not available elsewhere. The portal content will continue to evolve and expand as new data become available and in respond to demand. Obstacles around access to data, data governance and data sharing processes are all being successfully negotiated and the relevant documentation and processes delivered.

Outcomes analyses, not previously possible, are being undertaken using PHE data. Some of this is already published as dashboard reports; others are being prepared to be shared with the respective pathway teams.

We have already responded to a number of requests for data and intelligence.

Risks to this objective

1) Adequate funding to continue is not forthcoming reducing the capacity and effectiveness of the service
2) Loss of expertise due to uncertainty around continuity of contracts making staff retention difficult.
3) Under-performance due to lack of clear direction and support for the Service.

Recommendations

The Board is asked to note the contents of this report, the progress made and the risks to the delivery of the objectives.

Appendix

Screenshots of some reports currently available in the GMC Cancer Intelligence Portal