APPENDIX 3

TAMESIDE AND GLOSSOP COMMISSIONING INTENTIONS AND ACTION PAPER

The table below provides an update on the contributions required from Clinical Commissioning Groups to meet the level of ambition across Greater Manchester; these will be developed further and incorporated into the Locality specific plan.

	What do we need to do? - Update on the local position and next steps required.	When
Prevention, Earlier and better diagnosis		

1	Strengthen existing tobacco controls and smoking cessation services, in line with **reducing smoking prevalence** to below 13% nationally
	• Implement locality requirements outlined in the Greater Manchester tobacco control plan (expected April 2017).
	• Ensure effective and accessible locality based smoking cessation services are in place.
	
	Local Actions required
	• Raise awareness of lifestyle risk factors and change behaviour.
	• Help people to understand their individual risk of cancer.
	• Deliver lifestyle-based secondary prevention.
	
	Local Current Position
	• Be Well Tameside provides a person-centred, holistic service which is flexible and responsive to the needs of local people. The service operates on 3 levels.
	  ○ Support for multiple lifestyle issues (e.g. improving the quality of diet and nutrition, stopping smoking, reducing alcohol intake, increasing physical activity).
	  ○ Community Liaison, outreach and capacity building. The service works with residents, groups and organisations to promote Health and Wellbeing and encourage greater access to Be Well Tameside services.
	  ○ Training and Learning and Development. Be Well Tameside offers a health and wellbeing training programme to enhance and develop the competencies and skills of the wider public health workforce across organisations and the community. The training programme this year will include, Making Every Contact Count, Brief Advice/Intervention, Stop Smoking, Weight Management, Oral Health and other health related subjects.
	• Glossop has a newly commissioned Smoking Cessation service run by Derbyshire County Council/ Public Health.
	• Tameside are in their first year of a 3 year contract with Be Well (Pennine Care) who provides smoking cessation services for Tameside.
	
	Next Steps
	• Delivery model of lifestyle-based secondary prevention developed as part of new aftercare pathways by April 2018
	• Identify areas for Improvement.
	• Social care assessments for all age groups (lifestyle interventions that would impact positively on a family/individual) Youth and young
		By March 2020

	adults 16+ (12 years + for smoking support) • Consider innovative ideas to use Apps, software and website design for an interactive experience. • Greater Manchester population health plan produced by January 2017 • Greater Manchester tobacco control plan produced by April 2017 • Online tool for the assessment of individual risk of cancer available to people in Greater Manchester by September 2017.	
Prevention, Earlier and better diagnosis		
2	Work in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to test a GM wide **social movement focused on cancer prevention** **Local Actions required** • Create a citizen-led social movement **Local Current Position** • The local Cancer Early Detection Network links local stakeholders including: public health, Be Well, Bowel Cancer Screening Team, Cancer Research UK, workplace health, Macmillan GP, CCG commissioner, Tameside Macmillan Centre. • Be Well Tameside provide a training package on cancer symptom awareness for staff and volunteers in Tameside. Be Well are also recruiting and supporting volunteers, including some who are trained in cancer symptom awareness. • The Be Well service is a legacy from the Macmillan funded Community Cancer Awareness Project. **Next Steps** • Early Detection Network to oversee implementation plan.	By March 2019
Prevention, Earlier and better diagnosis		
3	Oversee roll out **primary care prescribing of drugs to prevent breast cancer**, subject to GM business case agreement **Local Actions required** • Prescribe drugs that are effective in preventing cancers. **Local Current Position** • Medicines Management Committee has had oversight of prescribing to date and this role will be picked up by the new Joint Medicines Optimisation Committee. **Next Steps** • Tameside and Glossop Clinical Commissioning Group Joint Medicines Optimisation Committee carry out Assessment of evidence of effectiveness of drugs to prevent breast cancer and business cases agreed by May 2017.	By May 2017
Prevention, Earlier and better diagnosis		
4	Improve access to, and uptake of, three national **cancer screening programmes** (bowel, breast, and cervical) and ensure a locality contribution to the overall GM targets of:	

	• Achieve bowel cancer screening uptake (FIT and scope) of 75% • Increase cervical screening coverage to 80% • Increase breast screening coverage by 10% to 75% **Local Actions required** • Enhance cancer screening • Increase public awareness of screening, and cancer signs and symptoms • Make the Manchester Cancer Improvement Programme lung health check available to all if successful • Pilot patient self-referral. **Local Current Position** • The local Cancer Early Detection Network links local stakeholders including: public health, Be Well, Bowel Cancer Screening Team, Cancer Research UK, workplace health, Macmillan GP, CCG commissioner, Tameside Macmillan Centre. • Be Well Tameside provide a training package on cancer symptom awareness for staff and volunteers in Tameside. Be Well also recruit and support volunteers, including some who are trained in cancer symptom awareness. • The Be Well service is a legacy from the Macmillan funded Community Cancer Awareness Project. • Pilot for Lung Cancer screening programme within Manchester Macmillan Cancer Improvement Partnership provided by University Hospital of South Manchester. **Next Steps** • FIT in use in bowel screening programme by April 2018 • HPV testing in cervical screening programme implemented by April 2018 • Bowel scope programme for 55 year old in place by April 2020 • Breast screening improvement trial reports findings in May 2017 • Bowel and cervical screening improvement trials report findings in October 2017 • Health equity profiles to identify areas of low screening uptake produced by July 2017 • Be Clear on Cancer branded campaign to promote bowel screening, January-March 2017 • Decision on implementation of MCIP lung health check across Greater Manchester by May 2017.	By March 2020 By March 2021
Prevention, Earlier and better diagnosis, Improved and standardised Care, Commissioning, provision and accountability and Patient experience and user involvement.		

5	**Improve one-year survival rates** to achieve 75%.
	• Deliver a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two –
	  ○ Agree data collection trajectories with providers to ensure robust and timely staging data collection
	  ○ Work in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to raise awareness of the signs and symptoms of cancer and encourage earlier
		By March 2020
		
		April 2017 onwards
		
		By March 2020

6	presentation and advice seeking
	
	• Reduce the proportion of cancers diagnosed following an emergency admission
	  ○ Contribute towards a GM reduction in the proportion of cancers that are diagnosed as an emergency to below 18%
	  ○ Implement strategies for all patients diagnosed as an emergency to have their cases looked at through a Significant Event Audit
	
	Drive earlier diagnosis by:
	• **Implementing NICE** referral guidelines
	  ○ Ensuring primary care adherence to use of updated standardised suspected cancer referral process and forms
	  ○ Support a GM approach to training and education for primary care professionals on cancer symptoms and referral processes
	• Ensuring local provision of **GP direct access** to key investigative tests for suspected cancer
	
	Local Actions required
	• Greater Manchester Cancer Volunteers – Raising awareness and Changing Behaviour
	• Implement the NICE suspected cancer referral guidelines
	• Improve adherence to NICE suspected cancer referral guidelines
	• Support pathway-specific efforts to deliver earlier and better diagnosis
	• Encourage Serious Event Audits (SEA)
	• Develop rapid cancer investigation units
	• Pilot patient self-referral
	• Reduce diagnostic waiting times
	• Contribute to regional improvements in diagnostic services
	• Agree data collection strategies to ensure robust and timely staging data collection.
	
	Local Current Position
	• GP TARGET sessions held in 2016 and 2017 .
	• Support available to Practices to reduce any variation
	• New GM wide referral proformas developed by ST & Macmillan GP colleagues in collaboration with MC pathway board clinical leads.
	• New e-referral templates installed on practice systems.
	• SEA of all emergency presentations to identify any key themes
	• ACE wave 2 Pilot of one-stop-diagnostic clinic for patients with non-specific symptoms at UHSM and PAHT from Jan 2017.
	
	Next Steps
	• GP use of updated standardised suspected cancer referral process and forms audited by June 2017 (Brain and sarcomas to follow)
	• Use of standardised suspected cancer referral process extended to other referrers by January 2018
	• Study into the impact of feedback on GP referral behaviour reports findings by September 2017
		By December 2017
		
		By March 2018

	• Regional haematological malignancy diagnostic service in place by January 2018 • Regional jaundice pathway for pancreatic cancer in place by January 2018 • Regional optimal lung cancer pathway implemented by January 2018 • Standardised approach to prostate cancer diagnosis agreed and implemented by January 2018 • Standardised approach to one-stop unexplained vaginal bleeding clinics by August 2018 • Pilot of straight-to-test pathway for colorectal cancer by October 2017 • Sector MDT model in colorectal cancer fully implemented by September 2017 • Pilot of streamlined oesophago-gastric cancer diagnostic pathway by January 2018 • Current provision of breast one-stop triple assessment clinics audited and plan developed by September 2017 • Non-specific but concerning symptoms clinic pilots start March 2017 • Faster pathways in Bolton for lung, colorectal and oesophago-gastric cancers by May 2017 • Share learning on faster pathways locally and nationally by December 2017 • Workshop to commence regional radiology development programme by March 2017 • Proposal for regional cellular pathology development programme produced by September 2017.	
Prevention, Earlier and better diagnosis, Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
7	Work with providers, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree a co-produced cancer **patient access charter**	By June 2107
Prevention, Earlier and better diagnosis, Improved and standardised Care, Commissioning and provision and accountability.		
8	Commission sufficient capacity to ensure 85% of patients continue to meet the 62 day **cancer waiting time standard.** Work towards achievement of the 28-day faster diagnosis standard. Ensure sufficient capacity for timed pathways for lung and HPB to deliver a • 50-day standard • 42-day standard **Local Actions required** • Reduce diagnostic waiting times • Contribute to regional improvements in diagnostic services • Speed up pathways to treatment **Local Current Position** • Consistently achieving the 62 day standard.	By March 2018 By March 2019 December 2017 December 2018

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	Next Steps • Faster pathways in Bolton for lung, colorectal and oesophago-gastric cancers by May 2017 • Share learning on faster pathways locally and nationally by December 2017 • Workshop to commence regional radiology development programme by March 2017 • Proposal for regional cellular pathology development programme produced by September 2017 • 50-day pathway in place in identified tumour types by December 2017 • 42-day pathway in place in identified tumour types by December 2018 • System in place to report average and range of waiting times for all pathways by April 2017 • Identify priority pathways by April 2017	
Improved and standardised Care and Commissioning, provision and accountability.		
9	Work collaboratively to develop a commissioning plan for an **integrated acute oncology service** for implementation in 2018 **Local Actions required** • Deliver an integrated acute oncology service • Lead oncology patient safety translational research **Next Steps** • Commissioning plan for integrated acute oncology service by October 2017 • Agreed model for integrated acute oncology service implemented by October 2018	By October 2017
Improved and standardised Care and, Commissioning, provision and accountability.		
10	Work collaboratively to develop and commission comprehensive **lymphoedema** services **Local Actions required** • Commission a comprehensive lymphoedema service **Local Current Position** • T&G ICFT lymphoedema service available **Next Steps** • Sustainable lymphoedema service by March 2020	By March 2020
Prevention, Earlier and better diagnosis, Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
11	Work with clinical pathway boards, hospital providers, people affected by cancer and other stakeholders to develop and agree an **optimal Greater Manchester specification** for each tumour type. GM Led approach.	To a timetable to be set by Greater Manchester Cancer

	Local Current Position • Living With and Beyond Cancer group and End Of Life Strategy Group progressing. • Annual Dying Matters events organised. **Local Actions required** • Ensure access to seven-day specialist palliative care advice and assessment • Deliver choice in end of life care • Ensure that shared digital palliative and end of life care records are rolled out **Next Steps** • A detailed map of specialist palliative care provision against national standards and competencies by March 2018 • An innovative economic modelling proposal for the delivery of a seven-day specialist palliative care advice and assessment by March 2018 • Qualitative and quantitative evaluation tools to measure the impact of seven-day specialist palliative care advice and assessment services agreed by March 2018 • Dying Matters Coalition events across Greater Manchester by May 2018	
Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
12	Lead the **implementation of the Recovery Package** through: A. A contribution to the development of a standard Greater Manchester approach, and B. Building the delivery of each of the Recovery Packages elements into commissioning specifications GM led approach Ensure all parts of the Recovery package are available to patients including: A. Holistic Needs Assessment and Care Plan at diagnosis and end of treatment B. Treatment Summary is sent to GP at end of treatment C. Cancer Care Review completed by GP within 6 months of cancer diagnosis **Local Actions required** • Commission the Recovery Package • Develop new aftercare pathways • Explore supported patient decision-making in progressing disease • Improve access to psychological support • Support people with long-term consequences of treatment • Earlier integration of supportive care into cancer care **Local Current Position** • Actively support Greater Manchester Recovery Package Implementation Group to agree standardised approach within	To a timetable to be set by Greater Manchester Cancer

	region by August 2017 • Facilitate a scoping exercise to understand what treatments are provided locally • Explore the introduction of an electronic holistic needs assessment. **Next Steps** • Standardised Greater Manchester approach to the Recovery Package agreed by August 2017 • Full Recovery Package available to all patients reaching completion of treatment by March 2019 • All patients receive a care plan at the point of diagnosis and treatment decision, and at the end of their treatment, based on holistic needs assessments, by December 2017 • Health and wellbeing events in place for all breast, colorectal and prostate cancer patients to support new aftercare pathways by March 2018, with models for other pathways developed by March 2019 • All patients receive a care plan at the point of diagnosis and treatment decision, and at the end of their treatment, based on holistic needs assessments, by December 2017 • Health and wellbeing events in place for all breast, colorectal and prostate cancer patients to support new aftercare pathways by March 2018, with models for other pathways developed by March 2019 • Full Recovery Package available to all patients reaching completion of treatment by March 2019 • New aftercare pathways defined and implemented for all breast, colorectal and prostate patients by March 2018 • New aftercare pathways pilots begin in further tumour types by March 2019 • Goals of Care tool tested in appropriate clinics at The Christie from March 2017 • Goals of Care tool pilot extended to other sites by March 2018 • Role of regional psychological support clinical group formalised by June 2017 • Psychological support clinical group to produce plan for improved access to psychological support by October 2017 • Potential consequences of treatment mapped by pathway by June 2017 • Assessment of current consequences of treatment expertise in Greater Manchester by June 2017 • Action plan to address any gap in support for consequences of treatment by September 2017 • Enhanced supportive care outpatient clinic piloted at the Christie centre at the Royal Oldham by April 2018.	
Prevention, Earlier and better diagnosis, Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
13	Ensure patients have access to Greater Manchester Cancer agreed **stratified follow up pathways** of care for ○ Breast cancer ○ Prostate and Colorectal cancer	By March 2018

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	Next Steps • Current provision of breast one-stop triple assessment clinics audited and plan developed by September 2017 • Health and wellbeing events in place for all breast, colorectal and prostate cancer patients to support new aftercare pathways by March 2018, with models for other pathways developed by March 2019 • New aftercare pathways defined and implemented for all breast, colorectal and prostate patients by March 2018 • New aftercare pathways pilots begin in further tumour types by March 2019 • Goals of Care tool tested in appropriate clinics at The Christie from March 2017	By March 2019
Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
14	Work with providers, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree system-wide **follow-up protocols** and create a timetable for offering stratified follow up arrangements dependent on risk. Greater Manchester approach. Refer to point 12 above.	By September 2017
Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
15	Ensure all patients have access to a **clinical nurse specialist** or other key worker Local Cancer Nurse specialists working across all Tumour pathways.	By December 2017