NHS
Greater Manchester
Cancer Alliance

GM Cancer Board Briefing

Monday 19th May 2025

Changes to NHSE/ICB Blueprint & Cancer Alliance Plans for 25/26

We have a number of challenges as a consequence of changes from an NSHE/ICB point of view. Financial planning process continues to be extremely challenged, and we are planning to have a significant deficit as a system in the 25/26 planning round following a significant deficit from the previous financial year. The plans submitted are challenged and there is scheduled to be a final resubmission of financial plans by ICB colleagues on 30th May. In the last month, have seen further requirements both financially and in the submission of plans with the launch of a Blueprint for the format of ICBs which needs to have its own plan submitted by 30th May. ICB colleagues are in the process of formulating these plans with several consultations happening with staff in the ICB and wider system/TPC this week. The substance of these plans requires significant change and reduction in staff and functions required in the ICB and must be transacted by Q3 of this financial year. In addition, providers have seen a requirement to halve growth of corporate services from the baseline of 2018/19 – the set of numbers issued by NHSE must be implemented. Last week, discussions with all NHS organisations in GM were held, looking at current plans in the system that have, consequently, got a headline reduction of 2,856 staff across all organisations - a lot more detail is associated with this.

The model ICB blueprint published last week describes role of the ICB as the strategic commissioner. Exactly what this means for GM is being worked through currently but includes a population health approach and how the total resource can be best allocated to serve the population needs across the system. The model ICB paper signalled several functions that will no longer sit with the ICB but are better placed with providers. Some of these mean changes to statutory responsibilities of the ICB and therefore will change as legislation changes. Mark Fisher spoke last week about role of Place and reaffirmed NHS GMs commitment to 10 places. There is a need to establish greater levels of consistency within the system by resetting 'Localities' as formal Place-based Partnerships and the new neighbourhood health and care provider vehicles. The ICB running cost (per head of population running cost) must be reduced by 39% for NHS GM, a very significant reduction and impact.

Dermatology Update

Heard previously around the issue with dermatology provision in the Oldham sector, traditionally run by a private company who had informed relevant people that they would be closing to new patient referrals as of 18th April – the date had been brought forward from the end of the year. AJ, LGD and ICB colleagues have contacted a company called Health Harmony/MediNet who are able to do some of this work but haven't delivered before so have put provision in place such as putting local skin MDTs into MFT temporarily. AJ added that Health Harmony will predominately be delivering the cancer pathway using the service specification that we wrote. Daily conversations with provider and colleagues at NHSGM are being had to ensure providers are in a place to deliver, and pathways are aligned. BI have supported providers in terms of reporting. We expect to hear re next steps and mitigations from colleagues in July.

Cancer Waiting Times Guidance update (V12.1)

New CWT guidance v12.1 was released in April and will be fully implemented from 1st July. LGD has so far delivered 3 webinars with 130 attendees and has attached a presentation and short briefing paper in the pack of the changes. The most significant differences are regarding the changes in the urology pathway and the breast symptomatic pathway. In urology, the use of mitomycin and how it can be applied as a treatment has changed, and breast symptomatic patients' pre-referral has changed. There is a meeting arranged with CGa to discuss this and look at a systemic approach for this. The draft access policy, also attached, correlating with CWT, is for review and LGD is asking for feedback by 27th May to sign off.

25/26 Cancer Alliance Delivery Plan

The GM Cancer Alliance 25/26 Delivery Plan has been distributed, a 2-part document with an Excel sheet of metrics and a Word document of the narrative. Submitted to NHSE in response to the requests in planning pack and deliverables required of Cancer Alliances, domains remain the same as last year. The plan was pulled together after extensive stakeholder engagement and consultation. Still awaiting feedback from NHSE, reliant on £11.1 m funding allocation from NHSE reaching the Cancer Alliance – followed ICB governance process and STAR form has been submitted. The STAR application has been paused and further discussions at Chief Officers is required as further clarity is needed around SDF funding. We are assured it will be resubmitted to the STAR panel this Wednesday. The ask of Board is to

approve plan as is, to progress programmes of work detailed within. There is a back-up plan of prioritised programmes. We have looked at what we can delay and adjust/remove, and the risks associated with this. Next board is 28th July so will update via email in the interim. Board supported approval of the plan.

Personalised Care - Genomics spotlight

Rachel Hart presented from slides that will be circulated with members after the meeting along with the minutes. Genomics sits within NHSE and as it is not duplicated has been less affected than some other services, but no uplift in funding this year. Relatively small decrease of 10% in GMSA but are already efficient in combining work in Liverpool and GM labs. Procurement for joint GLH/GMSA 2026 submitted last week – started working towards this with 2 main strategies; equity strategy, to make access to testing as equitable as possible, Northwest deprivation levels are high, need to start addressing this. Using data, we have to start understanding how we can increase engagement, talk to patients in these regions about issues they face, make it as evidence led as we can. Investing in digital and innovation strategies. Mainstreaming strategy - upskilling through education and training across the Board (CNS', GP'S, hospital-based teams), using data to make it easy to get access and results to testing and making it part of routine care,
CGIP (Cancer Genomic Improvement Programme) funded for 6 months from Sept-March to do transformation work. Funding for cancer genomic improvement programme to continue and task is to work within mainstreamed equity pathways to find the need and use quality improvement to target these groups. Working with Alliances to find other work in these areas already.

Early Diagnosis – Lung Cancer Screening Programme spotlight

There has been progress of the stage at diagnosis against 75% long-term plan. There has been something of a pause with release of data nationally, 3 months without monthly update. Have now had information through that brought our position up to Jan 25, gone past England average for the first time, exceeding 60% stage 1 and 2 diagnosis and 9th out of Cancer Alliances. Large difference between percentage point improvement in GM since 2019 compared to England average. Down to input, contribution and leadership of colleagues across all 10 GM localities.
OB presented the Lung Cancer Screening Programme Spotlight from slides circulated previously. OB highlighted and acknowledged the contribution from colleagues across GM in the success of the programme. £3.391m revenue funded repurposed by ICB to support increase in diagnostic activity using a specialist centre model across NCA and MFT. GM largest recipient of targeted funding, funding is also dependent on meeting targets being met across GM, carry out financial reconciliation in Q4, risk of revenue fallback in this programme.
OB shared some statistics for the programme in slides, as well as 25/26 plans and future challenges.

Faster Diagnosis & Operational Improvement & Treatment Variation

There has been a strong performance in 2024/25 with both key national planning targets for cancer being met. In terms of the Faster Diagnosis Standard, this has been achieved - 80.3% (vs. 77% target), and with 62-Day Referral to Treatment has achieved 71.6% (vs. 70% target).
SH/LGD gave a huge thanks to the whole system in delivering these, with particular thanks to the cancer managers, and the collaborative work.
Ambition for 25/26 – FDS & 62-day performance targets are rising, delivered 2 % increase in 62 days last year but needs to be 4% for this year. Trusts committed to delivering planning and trajectory in year but greater risk to performance with trusts with current situation – MFT have 13% difference between end of March 25 and end of March 26 for delivery for the trajectory which is positive. Work programme updates include improvement initiatives are underway and progressing and are critical for meeting 25/26 targets. Latest highlight being that the OG Cancer Survival and Treatment Optimisation Clinic has gone live.
Scoping the use of Federated Data Platform (FDP) to deliver current SQD projects, rollout for this across GM Cancer and non-cancer work from March 26. NICE guidance – have been given approval to skin analytics for an autonomous read, main difference is research element and working through what this looks like with case for change. Likely to be positive if technology is embraced and see clinical release time from using the system.