Meeting of the Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Operational Group
Wednesday 21st August 2019, 10:30-12:30
Board Room, Level 7 (C701) Bristol Heart Institute, Bristol Royal Infirmary, Marlborough Street, BS2 8HW

Present:

Amy Smith	CAG Administrative Coordinator	SWAG CA CAG Support Service
Caren Attree	Lead Cancer Nurse	Taunton and Somerset NHS FT
Carol Chapman	Lead Cancer Nurse	North Bristol NHS Trust
Catherine Carpenter-Clawson	Programme Manager	West of England Genomic Medicine Centre
Ed Nicolle	Cancer Manager	Royal United Hospitals Bath NHS FT
Hannah Marder (Chair)	Cancer Manager	University Hospitals Bristol NHS FT
Helen Dunderdale	CAG Support Manager	SWAG CA CAG Support Service
James Sanders	Communications Officer	South West Clinical Networks & Senate
Lynn Pearson	Head of Performance (for Zena Lane Cancer Manager)	Taunton and Somerset NHS FT
Natalie Heath	Operation Manager for Cancer	Yeovil District Hospital NHS FT
Nicola Gowen	Transformation Project Manager	SWAG Cancer Alliance, NHS England South West
Ousaima Alhamouieh	Transformation Project Manager	NHS England and NHS Improvement
Patricia McLarnon	Programme Manager	SWAG Cancer Alliance, NHS England South West
Ruth Hendy	Lead Cancer Nurse	University Hospitals Bristol NHS FT
Tara Harris	Cancer Information Manager	Salisbury NHS FT

Apologies:

Belinda Ockrim	Lead Cancer Nurse	Yeovil District NHS FT
Catherine Donnelly	Senior Analyst	Somerset Cancer Registry
Charlotte Kemp	MDT and Cancer Performance Manager	North Bristol NHS Trust
Elaine Farley	Analyst Coordinator	Somerset Cancer Registry
Emma Newbold	Deputy Lead Cancer Nurse	Weston Area Health NHS Trust
Emmy Scutt	Cancer Manager	Salisbury NHS FT
Hazel Lear	Product Specialist	Somerset Cancer Registry
James Curtis	Cancer Manager	Gloucestershire Hospitals NHS FT
James Withers	Data Liaison Manager	NCRAS
Luke Curtis	Cancer Manager	Yeovil District Hospital NHS FT
Rachel McConnell	Analysis Coordinator	Somerset Cancer Registry
Ruth McCarthy	Commercial Manager	Somerset Cancer Registry
Sian Middleton	Lead Cancer Nurse	Gloucestershire Hospitals NHS FT
Zena Lane	Cancer Manager	Taunton and Somerset NHS FT

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1. Welcome and apologies

H Marder welcomed all group members. Apologies received prior to the meeting were noted.

From the agenda:

2. Update from the Genomic Medicine Centre

Purpose: Summary of new Genomic Medicine Service

The 100,000 Genomic Medicine Project reached its goal of sequencing 100,000 genomes in December 2018. The contribution from SWAG Trusts to help achieve this was acknowledged.

For the cancer section of the project, 680 patients were consented from 11 tumour types with 537 samples passing quality control. Results are now coming through, some of which have actionable findings, such as the BRCA gene alteration, and could be useful in the event of a relapse. Genomic Leads have been appointed and attend monthly tumour board meetings.

Now that the project is coming to a close, provision of genetic testing is being restructured. The Severn Laboratory at Southmead has successfully bid to become one of seven Genomic Laboratory Hubs in England. A National Directory of Tests has been developed to give equity of access across the country. This includes access to tests for inherited cancer, whole genome testing for all patients with sarcoma, leukaemia and paediatric cancers (which will include patients up to 24-years-old), and genetic panels for other tumours.

The aim is to provide the tests from April 2020. Consultant Paediatric Haematologist John Moppett, from the Bristol Royal Hospital for Children, has been appointed as the Clinical Lead for leukaemia, and is working with C Carpenter-Clawson, a colleague based in Exeter, and the haematology teams to map the current pathways and embed genomic tests as standard care. Skin or biopsies will be required for germline tests; the process for collecting the samples will be provided.

Standard tests panels will continue until sufficient evidence is available to replace these with genetic panels.

Genomic Education and Training Lead Melanie Watson has been appointed to support the process.

The detail of cost implications and provision of the tests will be discussed further in a future meeting, to which the Head of the Genetics Laboratory, Rachel Butler, will be invited.

023/19 Action: H Dunderdale to invite R Butler to a future meeting

3. SWAG Cancer Alliance Case Studies

Purpose: To build a bank of case studies/good news stories

South West Cancer Alliance Communications Officer J Sanders aims to build a repository of good news stories, with the patient's voice at the heart of features. The initiative, envisioned by National Cancer Director Cally Palmer, is to build a profile across all regions to provide balance where often only negative stories are reported by the media. It will be possible to feature stories on the national website.

The South West Cancer Alliances will have a dedicated website to highlight regional good news; this could be from patients that have experienced Living With and Beyond Cancer activity, linked in some way with the national cancer agenda, and anything innovative occurring in cancer services at service level which could influence the Cancer Programme.

Examples might be sourced from the North Bristol Prostate Patient Pathway and other Cancer Alliance funded pathway initiatives. Other local service improvements, for example, initiatives undergone in the Paediatric and Teenage and Young Adult service can be included.

024/19 Action: H Dunderdale to circulate J Sanders' contact details

4. Notes and actions from the last meeting

022/19 Inability to separate prostate cancer patients from urology: The meaning of this action was uncertain. Action closed.

021/19 The urology service in Weston, is undertaking a piece of work funded by Turnbull-Fry; update pending.

021/19 Action D Brunton

020/19 Investigation of the Oxford team's initiative to train nurse practitioners as non-medical prescribers. Action closed.

019/19 Risks to CTF LWBC/Personalised Care Long Term Plan. Action closed.

012/19 Data reporting design and schedules. N Gowen is awaiting information from the Cancer Alliance but the action is no longer considered an operational issue. Action closed.

015/19 Cancer Waiting Times Terminology. There is a list of acceptable terms used by clinical coders (see Registerable Terms.pdf) that is useful for wording clinic letters to clarify outcomes; this will be included in the cancer access policy.

015/19 Action H Marder to circulate to all – emailed 21/08/2019

016/19 Cancer Alliance budget and plan 2019/20. On the agenda.

017/19 Prostate pathway project. It is not within the remit of the current nursing job descriptions to perform template biopsies. This should be done by trained practitioners. Action closed.

018/19 Colorectal pathway project: To share details of the colorectal pathway improvements in Royal Cornwall Hospital. Action closed.

039/18 Upper Gastrointestinal 2WW referral form: This will be amended as part of the OG pathway work. Action closed.

031/18 Prostate audit dataset: The dataset has been reduced as much as possible; all data fields left are necessary to inform the audit. Action closed.

007/18 Requirement for regional parity in the commissioning of reconstructive breast surgery post cancer treatment: Somerset CCG has agreed to fund the surgery. Action closed.

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005/17 Network-wide pharmacy and oncology posts. All Trusts aside from NBT have confirmed in writing the intention to fund the posts with the cost split between Trusts. H Dunderdale will amend the Service Level Agreement to commence in April 2020 and will send directly to M Plummeridge.

005/17 Action H Dunderdale to contact NBT; open until NBT sign off

5. Lead Cancer Nurse Update

Living With and Beyond Cancer (LWBC)

Purpose: To review LWBC activity and sustainability plan

5.1 National Cancer Patient Experience Survey (NCPES): Updates for 2020 with 'Picker'

Lead Cancer Nurse R Hendy provided an NCPES update for 2020 with 'Picker' from a recent Webinar. The next set of results is due at the beginning of September 2019.

For the 2019/20 financial year, Picker has been recommissioned to carry out the NCPES. Some changes have been made, for example, the fieldwork time has been reduced by 8 weeks; the list of relevant patients from April to June 2019, needs to be compiled for submission in the near future. Fieldwork will start at the end of October and results will be released in Spring 2020, significantly reducing turnaround time.

R Hendy has submitted an Expression of Interest to join the NCPES Advisory Group. Amendments are going to be made to the survey that should improve analysis. Trusts are invited to send representatives to 2 national workshops to share learning.

Changes to questions include:

- Q8. How long ago were people diagnosed with their cancer?

R Hendy acknowledged that the response boxes were a good start but didn't extend far enough. There is a need for more detail beyond a year to question >5 years ago or >10 years ago to truly capture a LWBC perspective.

- Q9. Who told you that you had cancer?
- Q69. Do any of these long term conditions reduce your ability to perform day to day activities? (A list of long-term conditions is provided)
- Q28. 'Operation' has been amended to 'overnight stay' to capture not just surgical patients.
- Q30. Did hospital staff talk in front of you?

Sampling will be much the same; Picker will remove duplicate submissions. Reminders will be sent via NHS England. The same method will be used to measure responses and the design will otherwise remain similar so that it is possible to compare results from previous years.

5.2 Living With and Beyond Cancer Evaluation

Please see the presentation 'COG LWBC Data.pptx'

The evaluation, which includes data still undergoing final analysis, will be updated for the Commissioners' meeting taking place on 9th September 2019. There are some gaps in the dataset, with no data submitted from YDH to date.

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UHB and RUH end of treatment summary numbers are included.

The number of interventions in WAH was queried as this was twice as much as UHB and NBT.

RUH already have an agreed tariff which is reflected in the level of activity reported. E Nicolle stated that there are dedicated support workers for colorectal, prostate and breast cancer, and a lot of work to improve the figures has been completed over the last 6 months. Activity can be uploaded on to the Millennium hospital information system, from which a report can be exported to simplify charging for the tariff. The 3 HNAs are Diagnosis, End of Treatment and Other (generally post cycle 2 of chemotherapy).

TST numbers are low and there is a need to unpick/understand what the issues are.

NBT are running Early Diagnosis clinics which is leading to some patients declining HNAs as they feel adequately supported without them.

Glos Holistic Needs Assessment (HNA) total is missing. D Goddard, C Neck and P McLarnon will look into this.

Commissioners have asked if HNAs should be completed by Cancer Support Workers given that this is reported activity.

NBT support workers phone patients 1 week after diagnosis, which is comparable with an HNA, and breast cancer patients have a 4 week post op service. CCGs are measuring HNA activity when a formal care plan is completed, but in reality, there are many other ways that holistic care needs are provided, which should ideally be measured and recognised as HNA activity.

Health and Wellbeing Event attendance numbers look positive across the board.

025/19 Action: P McLarnon to circulate presentation

Cancer Managers will meet to discuss recording activity

Trusts need to agree a preferred remote monitoring system. RUH, UHB and Glos are still to provide set-up cost information. £270,000 has been allocated, and the money can't be split until all trusts have provided costings. UHB have set-up costs available but are not remote monitoring at present. The Cancer Alliance preference is for a patient-facing portal system, but this is not mandated.

026/19 Action: Cancer Managers RUH, UHB and Glos to respond

NBT is not able to commence remote surveillance as GP practices are not funded to provide the necessary surveillance blood tests; patients with prostate cancer therefore have to come back to hospital for PSA monitoring. These are charged as an outpatient appointment, which is double the cost if undertaken in primary care. BNSSG Lead P Brindle is aware of the issue.

An options appraisal for ongoing funding of LWBC work in BNSSG had been drafted by H Marder, focussing on the healthcare economic aspects of the service. It showed that LWBC interventions in BNSSG were at least cost neutral to the healthcare community overall, based on nationally available peer reviewed evidence. It was very likely, but harder to evidence for certain, that significant cost savings would be possible.

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The national team had completed their tool for demonstrating amount of outpatient appointments released by stratified pathways.

A recent commissioning meeting attended by P McLarnon clarified the amount of follow up care that needs to remain in the realms of the acute sector. P McLarnon will discuss the BNSSG case with H Marder in a meeting extension following COG.

It was reconfirmed that national funding for LWBC activity will not be provided into the future. There is concern that it will not be possible to retain the CSW fixed-term post holders as current funding ends in 6 months. CCG Leads intend to make a decision on this issue by September 2019.

BNSSG predominantly use performance related (pay by results) contracts, rather than block contracts, although there is some mix and this may change. The BSW tariff had been agreed and in place for a year. It is hoped that this will continue; confirmation is expected at the end of the year. Somerset use block contracts and therefore the commissioning conversations are different.

5.3. Clinical Nurse Specialists/other cancer workforce initiatives

Purpose: To standardise job role provision

UHB: An additional Urology CNS has been appointed.

TST: An additional 1.6 WTE Colorectal triage Band 6 and 2 x Urology Band 6 (Macmillan funded) have been appointed.

NBT: A new post of a Band 5 inpatient based Cancer Support Worker has been funded by Macmillan to pilot over 3 years.

R Hendy indicated there is a need for more roles in psychological/emotional support, and clear boundaries need to be set for the Band 4 CSWs on the level of support that they can be expected to provide. The psychology team will be contacted to provide guidance.

027/19 Action: Liaison with Psych team

6. Cancer Waiting Times

6.1 Collection of the 28 day faster diagnosis dataset

Purpose: To review data collection issues/monitor compliance

A Cancer Improvement Workshop is due to be held in Taunton on 16th September 2019 to discuss issues and to make a collective list, particularly related to (a) collecting and (b) hitting the 28 day standard.

UHB: The main issue is determining the clock stop from clinic letters where the outcome is unclear. There are also challenges with timely data collection. Some patients (for example patients with interval scans) are kept on the pathway as a safety net, but results won't be submitted as they will be recorded after the month deadline. With patients who don't have cancer (gynae, head and neck and colorectal specialties), there is the issue of communicating this in a timely way with letters or phone calls to patients.

TST: Performance is at 70% across the board. Some tumour sites are very low. There are capacity issues with clinic letter turn-around time, in terms of the amount of medical secretary support

available. Also, with ever more sensitive scanning equipment, incidental findings are likely to increase, such as colorectal scans revealing a suspicion of renal masses, which involves a transfer to other MDTs. It was confirmed that the 62 day CWT clock could not be paused for these events. A faster diagnosis tracker will be discussed in the 2019/20 (agenda point 7.1) and is itemised in the Rapid Diagnostic section (agenda point 7.2).

RUH: Performance was at 80% due to coordinator capacity issues. Diagnosis only is being recorded for other patients. It was agreed that clarity of clinic letter outcomes is an issue. This is being discussed with all practitioners to avoid examples such as 'probably not a colorectal cancer'; for colorectal this is in the region of 24% of letters. Upper GI and Colorectal teams will be targeted.

YDH: N Heath also agreed that the main issue is clinic letters with clear outcomes. Further delays are expected in Dermatology in the short-term due to a change in Consultant workforce.

NBT: Recording the 28 day data has yet to commence. Some cancer sites have benign diagnosis template letters.

028/19 Action: C Chapman to share benign template letters with COG

Cancer Managers are asked to contribute agenda items for discussion at the Cancer Improvement Workshop.

029/19 Action: H Marder will collate a list of issues for circulation by 30th August 2019

7. Cancer Alliance & Transformation Funding

7.1. Review of 2019/20 Plan

Please see the presentation 'COGAug2019.pptx'

P McLarnon presented information concerning the NHS Long Term Cancer Plan through to 2028. £5.7 million is available for deliverables for next year. £900,000 is for Rapid Diagnostic centres and services. Further details are documented within the presentation.

Plan approvals in principle happened on 3rd June 2019 and were presented at the SWAG board meeting on 7th June. A lot of detail is missing, and the regional NHSE team want money committed and spent as soon as possible. The focus is on delivering a high-level but sustainable operating performance. 62 day wait target figures across the board have dipped during the last quarter. M Marsh is the new regional lead and S Berry is the interim Managing Director. Planning focus is on screening, earlier diagnosis and personalised care.

£210,000 will be focused on increasing capacity for Gynae and Head and Neck. It was confirmed that these funds were to be split equally between providers i.e. £25,000 each, as splitting pro rata would mean smaller providers would receive too little money to make any difference. All in agreement.

7.1.2 Rapid Diagnostic Service

Please see the presentation 'COG RDS and Lung Update Slides 15.8.19.pptx'

Cancer Alliances have been instructed by the National Cancer Board to spend 15% of 2019/20 funding (£900,000 for SWAG) on the development of a Rapid Diagnostic Service (RDS). Details on the potential service models for SWAG are within the presentation.

Expressions of Interest to host the pilot service have been received from the Mendips and Devizes Primary Care Networks (PCNs) and from the BNSSG on behalf of all PCNs in the region.

Diagnostic Access Agreements are required.

030/19 Action: N Gowen to forward slides for circulation

Cancer Managers were thanked for the National Optimal Lung Cancer Pathway reports submitted to date, and for continued submission of the reports every three months on the final Friday of each quarter.

A new NHSI Pathway Analyser Tool has been developed which requires manual upload of a random sample. Information can be filtered from the Somerset Cancer Register and entered rapidly once a sample has been identified.

It is hoped that this can be achieved in real time by Navigators or MDT Coordinators to enable live pathway analysis, and that software developments will automate digital upload in the future. The tool will be discussed further at the meeting on 16th September 2019.

7.1.3 Local anaesthetic (LA) template biopsy prostate pathway

The urology team in TST are keen to start performing template biopsies under local anaesthetic. A business plan detailing the training requirements and set up costs will be sent to P McLarnon. All centres in SWAG will be required to do the same. Equipment will need to be hired as it is not possible to spend funding over £5,000 on capital costs.

031/19 Action: L Pearson to submit business plan to P McLarnon

7.1.4 Review of provider Trust funding application

Cancer Managers are requested to submit funding applications in the near future.

Each representative present indicated that the Trusts would sign up to the aspects of the deliverables that are not already being met and are considered feasible to achieve.

Funding for administrative support with the 28 day faster diagnostic dataset will be automatically split between each Trust.

8. Any other business

Project Manager O Alhamouieh asked that the CMs submit the colorectal pathway dataset by Friday, 25th August 2019. The scenario-based section is with the clinical team in TST, who have agreed to complete it by the deadline.

Date of next meeting: Wednesday 16th October 2019, Board Room, Trust Headquarters, Bristol Royal Infirmary, Marlborough Street, Bristol BS1 3NU

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