Meeting of the SWAG Area Cancer Operational Group
Held on Wednesday 13th February 2019, 10.00-12.00
Macmillan Centre, Southmead Hospital, Donal Early Way, Bristol BS10 5NB

Present:	Asha Sahni	SSG Support Administrative Coordinator SWAG CA SSG Support Service
	Belinda Ockrim	Lead Cancer Nurse Yeovil District NHS FT
	Caren Attree	Lead Cancer Nurse Taunton and Somerset NHS FT
	Carol Chapman	Lead Cancer Nurse North Bristol NHS Trust
	Ed Nicolle	Cancer Manager Royal United Hospitals Bath NHS FT
	Emma Fynn	Cancer Services Improvement Lead Somerset CCG
	Hannah Marder	Cancer Manager University Hospitals Bristol NHS FT
	Helen Dunderdale	SSG Support Manager SWAG CA SSG Support Service
	Luke Curtis	Cancer Manager Yeovil District Hospital NHS FT
	Natalie Heath	Operational Manager for Cancer Yeovil District Hospital NHS FT
	Nicola Gowen	Project Manager SWAG Cancer Alliance NHS England South, South West
	Patricia McLarnon	Programme Manager SWAG Cancer Alliance NHS England South, South West
	Rebecca Lester	Weston Area Health NHS Trust Improvement Lead NHS Improvement
	Ruth Hendy	Lead Cancer Nurse University Hospitals Bristol NHS FT
	Samuel Wadham (Chair)	Assistant Director of Operations, Cancer & Emergency Planning North Bristol NHS Trust
	Sian Middleton	Lead Cancer Nurse Gloucestershire Hospitals NHS FT
	Suzanne Priest	Cancer Manager Weston Area Health NHS Trust
	Tara Harris	Cancer Information Manager Salisbury NHS FT
	Zena Lane	Cancer Manager Taunton & Somerset NHS FT
Apologies:		
	Claire Smith	Lead Cancer Nurse Salisbury NHS FT
	Deirdre Brunton	Lead Cancer Nurse Weston Area Health NHS Trust
	James Curtis	Cancer Manager Gloucestershire Hospitals NHS FT
	Jonathan Miller	South West Cancer Alliance Manager

1. Welcome and apologies

S Wadham welcomed all group members. Apologies received prior to the meeting were noted.

2. Notes and actions from the last meeting

An amendment has been requested to Page 6: Cancer Manager Z Lane presented the COG work on defining 28 day data collection to a local cancer steering group.

As there were no further amendments or comments following distribution of the minutes from the meeting on Wednesday 12th December 2018, the notes were accepted.

Actions:

039/18: Upper Gastrointestinal (UGI) Two Week Wait referral form: The form in Somerset is being revised as additional information may be required on the relevant blood tests to request in parallel with the referral. The BNSSG version will be sent to Somerset CCG, and this will be discussed at the next UGI SSG.

039/18: Action H Dunderdale

035/18: Bristol Macmillan Patient Experience Event: The event occurred yesterday; feedback will be shared once collated.

035/18: Action C Chapman

034/18: Potential rebranding of Site Specific Groups (SSGs) to Clinical Advisory Groups: The membership and remit of the current SSGs seems to match and add to the Terms of Reference available from alternative Clinical Advisory Groups. The Peninsula SSG Support Manager is in the process of drafting updated Terms of Reference, which may be adopted by SWAG. It is thought that encapsulating the purpose of the groups' in the revised brand name may help to highlight how important it is for key members to attend.

034/18: Action H Dunderdale

032/18: Cancer Transformation Funding (CTF) 2017/18 accountability: CTF accounting has been signed off for all 4 STPs. Reports on the impact of NSF Q1 & Q2 monies require some additional information.

032/18: Action P Mclarnon / Cancer Managers

031/18: Prostate audit dataset: The CA will keep data fields required for audits to a minimum in future. Data collection has ceased in NBT as the allocated sum of £3,000 has been spent and further funding is now required. IG compliance in terms of patient identifiable dates will be reviewed.

031/18: Action N Gowen

007/18: Requirement for regional parity in the commissioning of reconstructive breast surgery post cancer treatment: Somerset CCG has agreed to fund the surgery once an access policy has been completed. Timescales for its completion have yet to be defined; the CCG remains in breach of

national policy at present. SWAG Cancer Alliance Programme Manager P McLarnon will contact Somerset CCG to expedite the matter.

007/18: Action: P McLarnon

005/17: SWAG pharmacy and oncology chemotherapy protocol roles: The Cancer Alliance have agreed to fund the posts for a further 3 months while the Trusts arrange for the Service Level Agreement to be completed.

005/17: Action Cancer Managers

The actions completed and communicated to the COG group prior to the meeting are listed in the COG actions log. All other actions are on the agenda for discussion today.

From the agenda:

3. The new faster diagnostic 28 day target

COG plans to define a standardised regional approach for collection of the 28 day target dataset.

As a representative from the Bournemouth team, who piloted collection of the dataset, was unable to attend, questions had been sent out prior to the meeting to find out how this was achieved in practice. The answers did not provide the level of practical detail that the CMs had hoped to receive.

The ratio of MDT coordinators to cancer diagnoses was far higher in Bournemouth than in SWAG, which would account for feedback that the data collection was possible without extra resources. Additional administrative support would be required in SWAG.

Typing turnaround time of clinic letters, which will be used as evidence of the date when a patient has received results of tests to exclude or diagnose cancer, varied across the region and, in some cases, may not be available to report within the right month.

Clinic letter typing turnaround could be achieved in YDH; relevant Cancer Managers will check if letters that state 'dictated but not scrutinised' can be used.

001/19: Action Cancer Managers

In response to the question 'how do they define 'date told' when a patient is informed by GP or other non-hospital professional' the Bournemouth team said that it is the responsibility of secondary care to give patients their diagnosis, cancer or non-cancer, and not the responsibility of primary care once the patient has been referred via a 2WW pathway. This conflicted with GP direct to test pathways, and with the 28 day dataset definitions, which include an option for the GP to give the diagnosis.

Cancer Manager H Marder will share a formula that runs a Patient Tracking List query to help manage the longer list that will now include tracking of benign patients.

002/19: Action H Marder

The effect of the target on radiology capacity needs to be estimated and monitored.

The output from the October 2018 28 day meeting will be reviewed at the next COG meeting from a patient-centred perspective, which will be extended by one hour to accommodate the discussion.

003/19: Action Cancer Managers, Lead Cancer Nurses

Further information on the practicalities of collecting the data will be sought from the pilot site in Leeds.

004/19: Action H Dunderdale

To date, progress on collecting the 28 day dataset varied. YDH has been collecting the data for 6 months, TST are appointing a Band 5 Lead and will meet with clinicians and MDT coordinators to clarify the evidence required.

UH Bristol has focused on recording the data on straightforward cases where there is clear evidence that the patient has received a diagnosis. A member of the Cancer Service team will retrospectively review outstanding cases in April; it is not planned for the work to be done by MDT Coordinators.

RUH are completing the data for selected tumour sites, and putting together a business case for administrative support.

NBT will start monitoring the standard in April.

WGH need to address wider issues with data collection quality to ensure that there is a standardised approach prior to recording 28 day information. WGH and UH Bristol will discuss the management of shared lung patients.

005/19: Action H Marder / S Priest

Salisbury has appointed a Band 3 administrator to collect the dataset, which is being recorded for 78% of patients, although its accuracy needs to be validated. For Breast Cancer, 86% of 28 day data is being collected due to the provision of one stop clinics.

The 28 day faster diagnostic standard will be a rolling agenda item to monitor regional performance; data will be brought back for further discussion at the June 2019 meeting, and any requirements will be presented at future SSGs.

006/19: Action H Dunderdale / Cancer Managers

An event has been arranged on Thursday 7th March 2019 to provide additional information on how to implement the process.

There is a risk that the intended purpose of the target, to improve the time to cancer diagnosis, will be disadvantaged by the increased resource required to track benign patients; this will be raised with the Cancer Alliance.

007/19: Action Cancer Managers

The majority of Cancer Managers have decided not to validate the 28 day data collection due to the need to prioritise meeting the 62 day target.

The notes from the 28 day discussion will be amended to clarify that the Somerset CCG does not intend to disable the ability for referrals to be submitted if certain information is not available.

4. Cancer Waiting Times 62 day Performance Update

YDH: Performance for December 2018 was 79%, and 80% in January 2019. This has since recovered and the 85% trajectory is currently being met. However, the imminent loss of a radiologist is expected to have a significant impact on the breast cancer one stop clinic capacity.

UH Bristol: The target was achieved in the latter half of 2018, but performance dropped to 83% in January 2019 and February may be worse due to multiple critical care bed cancellations.

RUH: The target was achieved in November and December 2018, but this has dropped to 79% in January 2019 due to increased patient numbers across the board.

TST: The target had yet to be achieved, mainly due to breaches with colorectal cancer treatment and prostate with waiting times in Royal Devon and Exeter (often referred due to patient choice) for robot-assisted laparoscopic prostatectomy (RALP).

It was noted that RALP and cystectomy numbers have doubled in NBT.

NBT: The target was achieved in December 2018, but due to winter pressures it will not be met in January 2019. The new prostate pathway is gradually improving and a second robot will be available from April. There are some capacity issues with the breast cancer service due to staff shortages.

WGH: The target had yet to be achieved, which may in part be due to data collection issues. Other reasons include complex pathways and patient choice. The need to pause the clock for those patients who arrange to go abroad for the winter has been flagged with the national Cancer Waiting Times team.

Salisbury: The target was met in December 2018, will not be met in January 2019, and is hoped to recover in February. There are also recurrent issues with prostate breaches due to the RALP capacity in Southampton.

5. Lead Cancer Nurse and Personalised Care (formally Living With and Beyond Cancer) update

UH Bristol: L Castellaro's secondment to the LCN post will continue for another few weeks until the end of R Hendy's phased return. An action plan to address results from the National Cancer Patient Experience Survey is underway.

TST**:** Full complements of Clinical Nurse Specialists (CNSs) are in post. A business case is being developed to increase nursing capacity in urology and gynae. Living Well events are running well. There are issues with retaining Cancer Support Workers (CSWs). This has been recognised as a SWAG wide issue, which will hopefully be addressed once the Personalised Care Evaluation has been completed.

NBT: Breast Cancer Nurse Practitioners are being recruited to work alongside the CNS team, helping to run the 1 stop clinics. Over half of the medical workforce is due to retire in the next year; innovative posts are being considered to address shortages. The recent patient experience event run in collaboration with UH Bristol was well attended and generated a considerable amount of valuable feedback.

CSWs have been retained in post, but progress has been hampered by significant periods of sick leave. Recruitment to CNS vacancies is ongoing.

YDH: There are significant workforce shortages at present, particularly in the lung cancer service. The CSW team are successfully delivering Holistic Needs Assessments. Paperwork is being rebranded to match the language used in the NCPES. For example, the patient diary is going to be renamed as the 'Care Plan', and the meaning of clinical trials being for research purposes will be explained. An Upper GI CNS team, including one that can perform endoscopy is now in post. There is a need to rethink job roles; a Band 8A Systemic Anti-Cancer Therapy CNS is supporting urology, breast and gynae to reduce the oncology workload.

GLOS: Recruitment is going well, with a Skin and Neuro CNS recently appointed and a Band 7 Colorectal CNS post is currently out to advert.

The commissioning of Next Steps events held in the community, previously funded by Macmillan, has been delayed until March.

The Urology Team has been under pressure with three Consultants being off on long term sick leave. Hormone Workshops for patients and their partners, organised by a Band 4 Support Worker, have been well received.

A Quality Improvement project is being undertaken collaboratively by CNS, Allied Health Professionals (AHPs) and CSWs.

LCN S Middleton is due to retire in March and will return to work 2 days per week.

Sustainability of Personalised Care and Support beyond the funding available from the Cancer Alliance will be discussed further at the June COG. A tariff of £181.00 per patient has been calculated by RUH. Project Manager L Worswick will be invited to present the Evaluation to date.

009/19: Action H Dunderdale

CNS workforce planning is to be sent to Cancer Alliance Programme Manager J Miller

010/19 Action LCN team

6. Cancer Alliance 2019/20 plan

Information on the future vision of the Cancer Alliances was circulated and the regional plan will be discussed further in the next CA team meeting on Tuesday 27th February 2019. It has been confirmed that CAs are going to be established long term to provide continued clinical and operational leadership. SWAG has been selected for dedicated support to assist with this from a Tricordant expert organisational consultant; the CA Board has been extended by an hour to start this work and further information will be circulated next week.

The national focus is to improve and extend screening programmes and prevention and early diagnosis, including improving services for patients with serious non-specific symptoms by implementing rapid diagnostic centres. Pilot centres are based in secondary care, but SWAG plans to pilot a different solution that meets the needs of the regional geography.

The same amount of population based core funding is expected.

An interim report is available from the pilot sites; the full report will be consulted for further information as soon as this is available.

Information on Iron Deficiency Anaemia pathways has been requested.

Work is underway to mainstream genomic testing into standard practice.

Guidance for radiotherapy networks has been published. Peninsula Cancer Alliance Clinical Lead John Renninson will facilitate setting up the network groups, initially appointing a Chair and Manager who will be hosted by a provider, with accountability to the Cancer Alliance and specialised commissioning. A separate funding stream will be provided for this purpose.

SWAG Cancer Alliance Clinical Lead Amelia Randle plans to establish a Clinical Cabinet consisting of the Cancer Lead Clinicians, and will provide a date for the inaugural meeting in the near future.

There was pleasing progress with implementation of the Recovery Package. The template used to collect the data has been updated.

C Neck and L Worswick represented the CA at a recent national LWBC event where the successes and challenges of project teams were shared.

Dates for reporting CTF and NSF spending and monitoring of related progress have been circulated. The CA is frequently scrutinised for this information, and gaps have delayed the release of funds. Cancer Managers were not made aware of the missing information which had been circulated to the CCGs, and will be contacted individually to clarify any gaps in the data.

032/18: Action P McLarnon

At a regional assurance meeting, the Cancer Alliance had asked to include information on 104 day breaches and ongoing pathways in the reporting template.

Consultant Colorectal Surgeon Michael Thomas has been appointed as the Cancer Alliance Clinical Lead to work on implementation of the optimal colorectal pathway as recommended in a recent South West Clinical Senate meeting, facilitated by N Gowen.

Information from the 100 day project undertaken in Taunton will be shared.

Dermatology Services have been identified as a priority area for improvements; J Miller and A Randle will attend the next Skin SSG to offer assistance. The Upper GI pathway will be the next area of focus.

Consultant Respiratory Physician H Steer has been appointed as the Clinical Lead for implementing the National Optimal Lung Cancer Pathway.

Quarterly reports will be produced to provide updates on the progress of the pathway projects.

A Project Manager role to assist with national pathway work and cancer waiting targets, has gone back out to advert.

The CA currently reports to NHS E representative Julia Davidson (NHSE); the reporting pathways may change after the imminent merger of NHSE and NHSI.

7. Updates on colorectal, lung, and prostate pathways

Colorectal: Implementation of the Faecal Immunotherapy Test (FIT) test is now in the evaluation phase. How the straight to test pathway is implemented across the region will be the next area of focus.

Lung: The Quarter 2 evaluation is in progress – reporting times are challenging. SSG members will be invited to the Clinical Advisory Group meeting at the end of March.

Prostate: Key issues are the non-diagnostic MRIs and wait for biopsies. Once the key deliverables have been clearly defined and agreed, the Clinical Commissioning Groups will be approached to provide funding.

011/19: Action CA Project Managers

Clinical Lead R Persad is retiring next week and then returning part time.

8. Data resourcing

Please see the presentation circulated with the notes

Gathering data for evidence to drive transformation activities is a national developmental priority for Cancer Alliances. The current burden of other mandatory data requirements plus the addition to Cancer Alliance requests is recognised; however it is apparent that the need for data requests will increase, and resource, information governance, and the reporting design and schedules need to be defined. The CMs are asked to co-design these arrangements with the CA team so that the most effective support can be provided. Potential solutions are documented in the presentation. CM representatives are to send their feedback to N Gowen within the next three weeks for discussion at the next COG meeting.

012/19: Action Cancer Managers

9. SSG update

Administrative Coordinator A Sahni is moving to a role in Bristol University at the end of the month; the post is currently out to advert. MDT Assessment Tool Training Days, funded by the Cancer Alliance, are due to be held on Wednesday 19th and 26th June 2019. The invite will be forwarded to Salisbury Cancer Manager T Harris to forward to the clinical team.

013/19: Action H Dunderdale

10. Any other business

RUH are planning to pilot Teledermatology to assist with triaging patients to the correct pathway.

Date of next meeting: Wednesday 17th April 2019, 10:00-12:00, Gloucestershire Hospitals NHS Foundation Trust

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