Meeting of the Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Operational Group
Wednesday 12th February 2020, 10:00-12:30
Brentry Room, Level 2 Seminar Tower, Green Zone, Southmead Hospital, Bristol

Present:

Amy Smith	CAG Administrative Coordinator	SWAG CA CAG Support Service
Belinda Ockrim	Lead Cancer Nurse	Yeovil District Hospital NHS FT
Caren Attree	Lead Cancer Nurse	Taunton and Somerset NHS FT
Carol Chapman	Lead Cancer Nurse	North Bristol NHS Trust
Charlotte Kemp	MDT and Cancer Performance Manager	North Bristol NHS Trust
Ed Nicolle	Cancer Manager	Royal United Hospitals Bath NHS FT
Helen Dunderdale	CAG Support Manager	SWAG CA CAG Support Service
Luke Curtis	Cancer Manager	Yeovil District Hospital NHS FT
Nicola Gowen	Project Manager	SWAG Cancer Alliance
Patricia McLarnon	Cancer Alliance Programme Manager	SWAG Cancer Alliance
Ruth Hendy	Lead Cancer Nurse	University Hospitals Bristol NHS FT
Tariq White	Cancer Alliance Managing Director	SWAG Cancer Alliance
Tara Harris	Cancer Pathway Manager	Salisbury NHS FT
Terri Agnew (Chair)	Cancer Manager	North Bristol NHS Trust
Zena Lane	Cancer Manager	Taunton and Somerset NHS FT

Apologies:

Amanda Bessant	Macmillan Specialist Nurse	Weston Area HT
Catherine Donnelly	Senior Analyst	SCR
Claire Smith	Lead Cancer Nurse	Salisbury NHS FT
Corrine Thomas	Part-time and fixed term Lead Cancer Nurse/Matron	Weston Area HT
Elaine Farley	SCR Analyst Co-ordinator	SCR
Emilia Scutt	Cancer Services Manager	Salisbury NHS FT
Hannah Marder	Cancer Manager	University Hospitals Bristol NHS FT
Hazel Lear	Product Specialist	SCR
James Curtis	Cancer Manager	Gloucestershire Hospitals NHS FT
James Withers	Data Liaison Manager	NCRAS
Julia Stroud	Associate Director of Nursing (interim Lead Cancer Nurse)	Weston Area HT
Michelle Gregory	Deputy Cancer Manager	University Hospitals Bristol NHS FT
Natalie Heath	Operational Manager for Cancer	Yeovil District Hospital NHS FT
Ousaima Alhamouieh	Transformation Project Manager	SWAG Cancer Alliance
Rachel McConnell	Analysis Co-ordinator	SCR
Ruth McCarthy	Commercial Manager	SCR
Sally Hayes	Lead Cancer Nurse	Gloucestershire Hospitals NHS FT

1. Welcome and apologies

T Agnew welcomed all group members. Apologies received prior to the meeting were noted.

From the agenda:

2. Notes and actions from the last meeting

Notes from the last meeting held on 11th December 2019 were accepted with no amendments requested.

046/19 To include CAG Roles and Responsibilities in the COG Terms of Reference. H Dunderdale has added descriptions to the bottom of Terms of Reference; action closed.

T White clarified that the Cancer Alliance funding plan for 2020/21 has been discussed at a meeting in January 2020 and on Monday 10th February 2020. The discussions and proposal will be raised at the Cancer Alliance Board on 13th March 2020. The Alliance will cover a percentage of the costs

associated with Personalised Care and Support, tapered over the next three years: 75% in 2020/21, 50% in 2021/22 and 25% in 2022/23. Agreement will be sought from the CCGs to meet the staged deficit. From 2023/24 onwards, costs will need to be funded by the CCGs.

The Business Case for Remote Monitoring in NBT has been ratified by Cancer Board and will be reviewed by the Trust Board in the second week in March.

In UH Bristol, the procurement process is still underway and is currently being analysed by the Finance Department. This may be altered to include Weston.

It was re-emphasised that any fund held by BNSSG that are not invoiced for by the end of March 2020 would be lost.

It is hoped that funding for data analyst roles to support completion of CA data requests will be incorporated into the CA plan.

045/19 Circulation of the table of CAG meetings and CM / LCN attendance. H Dunderdale has circulated and Cancer Programme Manager R Edgerly has agreed to cover Colorectal and CUP. Item is on the agenda; action closed.

043/19 National Cancer Register TNM Versions Used. TNM versions have been checked in most centres. Gloucestershire was not in attendance for comment. E Nicolle will check if this has been resolved with J Withers; action closed to COG.

042/19 Circulation of the Rapid Diagnostic Service Event slides. NG circulated slides 12/12/2019; action closed.

041/19 Develop a List of all Data Requests and Returns required by the Cancer Alliance Board.

001/20 Action: CA will send out a list of the data requests as soon as this has been clarified. N Gowen will send calendar invites via email with reminders the week before returns are due.

039/19 Clinical Advisory Group Service Level Agreement (SLA) Final Sign Off: The SLA will be recirculated to the Trusts where sign off is pending.

034/19 Gloucestershire Next Steps Commissioning: update pending.

032/19 Attendance at NCPES Cancer Advisory Workshops: No dates are available yet; R Hendy will circulate when available.

028/19 Benign Day 28 Template Letters: There is not one letter that covers all specialties, differences are needed. T Agnew is happy to circulate a sample letter to those interested; action closed.

027/19 Development of Emotional /Psychological Support Roles: clarification of whether this is being built into the Transformation plan was sought. T White is meeting with Consultant Psychologist J Raynes tomorrow to discuss further.

002/20 Action: T White to feedback clarification of role funding from meeting 13th February 2020

3. COG Terms of Reference

3.1 COG Terms of Reference Update

The Terms of Reference were reviewed for comment. Amendment requests included:

- Refer to seven Trusts, not eight, to take into account the merger of UHB and WHAT in April.
- NCRAS name change confirmed.
- UWE attendance. This has become an annual update rather than attendance. H Dunderdale will email to clarify if this will still be provided.
- References to Macmillan will be removed and replaced with Third Sector Providers.
- Cancer 'Network' Clinical Advisory Group will change to 'Alliance'
- The Lead Cancer Nurse role will be amended, with removal of review of patient information leaflets and arrangement of CNS breakout meetings and inclusion of Personalised Care and Support.

Clarity was sought on the role of COG meetings in terms of Performance. Meetings are an opportunity to discuss the longer term view and national guidance and to strengthen intra-hospital relationships.

Membership should remain Cancer Managers and Lead Cancer Nurses. In hospitals where there is more than one role (e.g. Operational Manager), deputy representation can be sought. L Curtis stated that N Heath will be taking more of a lead on Cancer Management at YDH in future.

003/20 Action: HD to amend and circulate again for COG review and sign off.

It was noted that all CAG meetings are based on the same template agenda. Although this includes Quality Surveillance (QS), there have not been any related items to add to recent agendas. COG opinion is to provide CAGs with a steer of the wider strategic view with CAG members maintaining their own governance.

004/20 COG members to send any strategic/QS elements for CAG meeting agendas to H Dunderdale.

4. Cancer Alliance & Transformation Funding

4.1 Cancer Alliance Update

T White met with the National Cancer Programme Director; the following is a flavour of the national discussion. The new government context is changing rapidly. They want to take advantage of low interest rates. Health is a big priority but there will be even more scrutiny on Performance, particularly 62 Days. This was a question at the first session of Prime Minister Questions. England national performance is at 78%, predictions for January had been 75% but the actual figure is 72%. This is a major concern, along with Delivery, ROI etc.

The Alliance will focus on reinforcing leadership within the long-term plan. Funding has been settled for the next five years. CCG planning and operational guidance recognises the role of the Alliance in improving performance. The plan of how Operational Performance can be improved should be treated at the same priority level as Early Diagnosis; it may be even be more important.

P McLarnon mentioned the Masterclass (see Agenda item 4.2). This will include strategies on how to improve performance. Discussion to finesse the CADEAS data is underway, to establish one version of data for consistency. All 19 Cancer Alliances have fed back the challenges around diagnostic capacity, and the National Cancer Board acknowledged that they had been slow to address this, and have now formed a National Diagnostic Programme Board and Workforce Board, attended by the National Medical Director.

At the Cancer Alliance Planning Meeting on Monday, a presentation was provided by a representative from the company ATTAIN, who have mapped diagnostic capacity and demand, including workforce for several Cancer Alliances (including all diagnostic services and not just cancer), and the plan is to do so for SWAG, if the outputs from the projects, which can be completed in approximately 3 months, have been found to be of benefit.

005/20 Action: T White to liaise with Thames Valley Cancer Alliance about project outputs

There is a Diagnostics Advisory Group in NBT, and the CA will ensure that the group is informed of the plan of work to avoid duplication.

Excluding budget for core team, the funding for next year is £4.5m. Cancer Managers should think about infrastructure needed to support operational performance and think about opportunities in other sites and work up plans. 28 day and 62 day remain important targets. Although funds will be released in June 2020, spending can commence in April 2020, and MoUs can be signed off for assurance in March 2020.

Polyp surveillance is an important focus; additional funding of £387K will be available for implementation. S Berry is leading this on behalf of the South West and a Clinical Lead will be appointed by Q3 of this year. It was queried if this would be linked with bowel screening.

The deadline for implementing the National Optimal Timed Cancer Pathways for Lung, Prostate, Colorectal and OG Cancer in full is April 2020; it was recognised that the deadline could not be met in SWAG with existing resources. Rigorous audits of the pathways are required to establish how each Trust is managing the pathways and to provide proof of the shortfalls. The templates for the audits will be recirculated on Monday 17th February 2020 for completion by end of April.

006/20 Action: Cancer Managers to complete timed pathway template by April 2020

The Rapid Diagnostic Service may have the ability to fund additional diagnostic activity by extending the remit from non-site specific symptoms to include site specific symptoms.

4.2 Cancer Alliance Masterclass, 25th February 09:00-16:30 London

Details of the Masterclass, to be held on 25th February 2020, have been circulated. All are urged to send relevant staff.

5. Lead Cancer Nurses Update

5.1 LCN Roles and Responsibilities

Purpose: To compare regional LCN roles

LCN job descriptions vary widely across the SWAG region. The roles in UHB and NBT are entirely strategic; the Job Description in YDH is similar, whereas in TST, it is badged as a matron role with additional operational responsibilities. It is the consensus of COG that it should not be a dual role.

007/20 Action: T White will work with R Hendy and C Chapman to reach consensus on the Job Description and discuss with the Clinical Cabinet.

5.2 Personalised Care CNS/CSW Workforce

Purpose: To review LWBC activity and sustainability plan

Contracts for the staff appointed to undertake Personalised Care activity have been extended until September in UH Bristol and NBT, but not in Somerset. Funding of 75% for 2020 will be sanctioned at the CA Board on 13th March 2020. Somerset needs STP decisions and long-term solutions before the end of February 2020. T White is working with Andy Hills at Somerset and they are trying to get commitment before the Alliance Board meeting. The caveat is, if STPs don't pick up the 25% shortfall, total funding will be 75% of this year's budget.

5.3 Macmillan New and Existing Post Adoption

A complete review of Macmillan post-holders has been undertaken at UH Bristol. There are 85 posts, but a lot are out-of-date. It should be possible to slot in some people waiting to be adopted to reduce the waiting list. Some posts could be unadopted if not considered a priority. Criteria has been written by R Hendy, and will be shared.

008/20 Action: R Hendy to share written criteria

When securing new posts, Macmillan now required measurable outcomes to be regularly reported on the benefits that the roles provide. Macmillan's focus is on continued provision of CNS posts to acute providers, and not on other Allied Health Professional.

5.4 Changes to National Cancer Patient Experience Survey (NCPES)

NCPES has subdivided into 4 main workshops. R Hendy attends the sampling and reporting subgroups. The next set of results will be available in May/June 2020, and will include a more formalised comments report with a 'strength of sentiment' analysis of the comments. Reports could be presented across pathways in future. It is planned to capture more information on primary care and hard to reach groups, and hopefully lengthen the distribution period for rare cancer sites. The new survey will ask the approximate year when people were diagnosed. Dates for provider workshops will be circulated when available.

5.5 Assignment of Clinical Advisory Group Meeting Attendance

H Dunderdale circulated the attendance chart prior to the meeting. J Curtis has been assigned Brain and Haematology CAGs in his absence, with E Nicolle deputising for Haematology. Z Lane will attend Gynaecology CAGs.

LCN C Atree will assign one of the new Band 8A nurses to deputise and attend the Colorectal CAG. The table will be updated and re-circulated.

6. Network Issues

6.1 Lung CAG Query

It was raised in the Lung CAG to agree the clinical tests that need to be performed by local centres before a referral can be accepted by the surgical team in UH Bristol. The surgical team will liaise with H Marder once this is defined.

009/20 Action: H Marder / Thoracic surgical team.

6.2 Clinical Advisory Group Update

Purpose: To share overarching and site specific priorities/initiatives

A Memorandum of Understanding between the Cancer Alliance and UH Bristol has been signed that will reimburse of the cost of the CAG Service to provider Trusts for next four years. The CAG Service Level Agreement has been updated to include support for the Paediatric/TYA network group (the first meeting of this group is tomorrow), and a Systemic Anti-Cancer Therapy (SACT) group. The Chair of the previous cancer network chemotherapy group has been contacted for advice on the initial approach to take prior to contacting the wider team.

MDT reforms are underway, as documented in the report circulated prior to the meeting. Three MDT-Mode assessments have been completed to date, for the Breast Cancer team at NBT, and the Gynae and HPB team at UH Bristol. The results have been useful to inform areas for improvements within the meetings. Once complete, results will be shared with Cancer Managers.

010/20 Action: H Dunderdale to circulate MDT-Mode results when complete

Administrative Coordinator A Smith is assisting with data collection for network audits, most recently for a thyroid follow up audit and a dataset (sourced from NBT pharmacy after arranging a data sharing agreement with the relevant Caldicott Guardians) that will enable the sarcoma team to meet the requirements of the 2019 service specification.

There are now 291 SACT protocols on the SWCN website; the webpage was accessed by >17,500 unique page views in Quarter 4. A database of the protocol work, kept up to date by Consultant Pharmacist S Murdoch and H Dunderdale, is available to view on request.

NHS England is in the process of developing national 'Standards of Care', with the aim to have the lung and prostate guidance ratified by the 20th March. The clinical lead for Lung is attending the round table meeting in London for this purpose. Local versions have already been developed by several teams; MDTM streamlining initiatives, steered by the Clinical Lead group, will be shared with COG, along with the Work Programmes for the CAGs.

7. Cancer Waiting Times

7.1 Performance and General Update

RUH are struggling with 2WW, predominantly more patients are being seen through colorectal appropriate pathway. Telephoning but not quickly enough. The first diagnosis is approximately 2.5 weeks. Skin is a significant challenge due to lack of capacity. Teledermatology.

28D is at 75% data completeness but 80% is achievable. Performance is at 82/3% data completeness currently but is expected to drop. 62D is consistently not achieved, due to a handful of breaches. Colorectal and prostate have had complex pathways in the last few months. The Rapid Diagnostic Service may help. N Gowen stated the referral would be made once and then pull into a site specific pathway. If cancer is still suspected this will be managed internally. Most pathways already have some sort of facility for this.

Diagnostics is the main but not the only challenge. This is due to waits for oncology and chemotherapy and an inability to recruit.

YDH are struggling with 2WW due to skin and workforce issues. The hospital is reliant on locums. 28D has no outstanding mandatory data, each month is cleared. Approximate completeness is at 78% but a 39% figure for Urology brings it down. 62D is quite good due to pathway redesigns. YDH failed in October but otherwise passed consistently. February data was at 86% but radical surgery and urology will have an effect. 31D YDH Jan and Feb will be bad because of skin. Urologists would like to see GPs request directly. Tim is very keen on that. 2 PSAs rather than just one. Looking at 2WW referral form.

NBT managed to get 31 days but struggling DTT 24 days. There is active weekly monitoring looking at 28D data. 104 day reviews. Backlog clearance is not stopping the flow. In terms of breaches across the quarter 19 were urology, 6 UGI and other sites have no more than one each.

TST Q3 2WW mainly struggled due to endoscopy capacity but also Colorectal. The 28D data is just meeting the 70% target. There is some work to do with colorectal screening. Data completeness is in high 90s. Data recording is going really well. They are stopping the clock later than needed for some patients. A project group, the Faster Diagnosis Hub, look at 28D standards.

31D is pretty good. New standards and merging should help. There are Lung and Medical Cause issues. 62D main areas are prostate and RALP wait. Colorectal referral figures are increasing constantly.

It takes 17-19 days to get an MDT decision to get radiotherapy. RIG for radical radiotherapy at YDH.

The national steer is focus on Cancer Waiting Times without consultation. N Gowen will try to chase. Opinion is the Clinical Board should look at this. Dental extractions is positive. Conferences London and Exeter – said about going out for consultation but none had. National Guidance less than 1 month. Stephen Scott works on this one day per week.

Z Lane discussed 28D splits with NHSI last week, querying why data is segmented. The issue is the breach allocation if Trusts don't populate segments. Clarification was sought regarding responsibility for patients transferring within the data flow. Z Lane will share feedback.

NBT data completeness went from 0 to 90. UHB did not have the same issues.

NBT has similar challenges with 2WW; there is still an issue Skin, due to huge rises in demand but no rises in primary. Dermato – don't know. Teledermatology has not moved forward much but has to start in Primary care. If this was on Medway and accessible to all, demand should regulate. Rates are between 0.8 to 0.85. Should have a significant impact on Sarcoma.

There have been quite big inroads with Urology. 31D performance is better at 80 something% from 50 something. A second robot is up and running. LATP pathways are running but it's the volume.

There are capacity issues for sentinel node biopsies but these are being addressed. This is a constant issue. There is a fairly good trend upwards across all standards but this is not sustainable yet. For Diagnostics, there are a lot of factors affecting endoscopy. These include: Outsourcing; evening, weekday and weekend lists are all running. The 28D target might be met. Completeness is consistently above 76% and pathway reviews this month will keep pushing forward. The number of patients going from colonoscopy to screening has gone up.

Z Lane queried who should attend the workshop event. NBT will suggest all tracker validator people attend.

Salisbury are struggling at around 70-80%. This is a coordinator recording issue. Also workforce issues of employing locums, training them but having unsecured contracts means they leave. A lot of data completeness has to be reviewed at the end of month. 62D data just scraped 43. Only due to 2 metastatic patients recorded as suspected primary. Q4 is looking horrendous at 61%. There have been a shocking amount of breaches. These include Head & Neck and haematology tumour sites and also urology.

There are struggles with pathology, which is outsourced (but not outsourced for 2WW if possible). The hospital is down by 2 pathologists and the 3 working cannot cope.

NBT suggestion is to look at BSM/N level. This could drive a cultural revolution.

7.2 Any other business

No further business was raised. T Agnew thanked all COG members present for attending.

Date and time of next meeting: 10:00-12:00 Wednesday 15th April 2020, Gloucestershire, room to be arranged.

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