SWAG Cancer Alliance

SWAG Cancer Alliance Board Minutes

Board and Biffen Rooms, Gloucestershire CCG, Sanger House, 5220 Valiant Court, Gloucester Business Park, GL3 4FE

Present	Title	Representing
James Rimmer (JWR)	Chair	SWAG Cancer Alliance
Dr Amelia Randle	Clinical Lead	SWAG Cancer Alliance
Dr Dorothy Goddard	Living With & Beyond Cancer Clinical Lead	SWAG Cancer Alliance
Dr Sadaf Haque	Prevention and Early Diagnosis Clinical Lead	SWAG Cancer Alliance
Patricia McLarnon	Programme Manager	SWAG Cancer Alliance
Nicola Gowen	Transformation Project Manager	SWAG Cancer Alliance
Helen Dunderdale	SSG Support Manager	SWAG Cancer Alliance
Sunita Berry	Interim Cancer Alliance Manager	SWAG Cancer Alliance
Hannah Marder	Cancer Manager University Hospitals Bristol NHS FT	SWAG Cancer Operational Group
Carol Chapman	Lead Cancer Nurse on behalf of LCNs	SWAG Cancer Operational Group
Ruth Carr	Regional Cancer Programme Manager	NHS England, South West
Charlotte Ives	Transformation Delivery Manager	NHS England & NHS Improvement
Helen Crick	Head of Delivery and Improvement	NHS England & NHS Improvement
Julie Yates	Lead Consultant South West Screening & Immunisation	NHS England & NHS Improvement
Katharine Young	Associate Director of Strategy & Transformation	NHS England & NHS Improvement
Ulrike Harrower	Public Health Consultant	Public Health England South West
Liam Williams	Director of Commissioning Performance	NHS South, West & Central Commissioning
Alison Wint	Cancer Clinical Lead	BNSSG STP
Andy Jennings	Head of Acute Commissioning Wiltshire CCG	BSW STP
Kathryn Hall	Associate Director, Service Improvement and Redesign	Gloucestershire ICS
James Curtis	Cancer Manager Gloucestershire Hospitals NHS FT	Gloucestershire ICS
Katharine Jones	Macmillan Project Manager	Gloucestershire ICS
Carla Griffiths	Assistant General Manager	North Bristol NHS Trust
Rosanna James	Deputy Chief Operating Officer	North Bristol NHS Trust
John Graham	Consultant in Clinical Oncology & Cancer Lead Clinician Musgrove Park Hospital	Somerset STP
Rachel Rowe	Head of Long-Term Conditions	Somerset STP
Alastair Mitchell-Baker	Director	Tricordant
James Sanders	Communications Manager	SW Clinical Networks
Christine Teller	Public Contributor	NHS England Public Contributor
Jennifer Hepworth	Patient Representative	SWAG Patient Representative
Deborah Haworth	Regional Manager, Wessex, South Wales and South	Cancer Research UK

	West	
Helen Dunderdale	SWAG Cancer Alliance CAG Support Manager	SWAG Cancer Alliance Support Service
Amy Smith	SWAG CAG Administrative Coordinator	SWAG Cancer Alliance Support Service
Apologies		
Katy Horton-Fawkes	Patient & Public Engagement Lead	SWAG Cancer Alliance
Ruth Hendy	Lead Cancer Nurse on behalf of LCNs	SWAG Cancer Operational Group
Blanka Stead	Senior Project Manager	NHS South, West & Central Commissioning
Marie Couturier	Specialist Information Manager	NHS South, West & Central Commissioning
Sarah Warren	Programme Manager	NHS South, West & Central Commissioning
Sarah Dove	SW Screening & Immunisation	NHS England
Nicola Hawkins	Consultant Cancer AHP & Cancer Rehabilitation	Gloucestershire CCG
Terry James	Commissioning Manager Cancer Lead	Wiltshire CCG
Jonathan Cullis	Clinical Lead for Cancer Transformation/Co-Chair BSW STP	Salisbury NHS FT
Tara Harris	MDT Office Team Leader	Salisbury NHS FT
Caren Attree	Lead Cancer Nurse TST	Taunton NHS Trust
Peter Wilson		University Hospital Southampton
Natalie Heath	Cancer Service Team Leader	Yeovil District Hospital NHS Trust
Christine Nagle	Facilities Manager	Cancer Research UK
Christopher Scally	Strategic Partnership Manager – South West England	Macmillan
Wendi Abraham	Partnership Manager	Macmillan

Welcome and Apologies

JWR, Chair, welcomed everyone to the meeting, and apologies were noted as above. JWR stated a declaration of interest for the minutes. He is no longer Chief Executive of Weston Area Health NHS Trust but CE of Somerset CCG; having discussed with Dr Michael Marsh Regional Medical Director and all SWAG organisations Chief Executives' he will continue in his role as Executive Lead of the Alliance until the end of the financial year. As Chair his focus will continue to be fair and impartial and ensure appropriate governance. He expressed concern that progress of Alliance business since the previous board in June was not as he expected, and he did not feel sufficiently briefed on Alliance business due to the lateness of papers. Therefore he asked members for delegated authority outside of the board to ensure processes were made right going forwards. He reminded all members we are dealing with significant amounts of public funding, and therefore we need processes to be right. He acknowledged the change in core team leadership over the summer as a cause factor.

Action: Core Alliance team to publish Board papers 2 weeks in advance

1. Notes of the Last meeting and Matters arising

Notes and actions related to the last meeting (***SWAG Cancer Alliance Board 070619 Draft Notes JWR***; ***SWAG Cancer Alliance Actions Board 7 June 2019***) are located here.

Regarding open actions, Agenda Item 6 risk of sustainability will be dealt with during this meeting, so this can be closed

JWR commented section 2 '2019/20 Operating Plan and Funding' paragraph 2 and 3 of draft June board notes do not capture the discussion or principles agreed. The minutes should reflect the following principles:

- This is focused project work and not all Trusts will participate;
- But the intention with the funding is to achieve board brush equity and spread across the STPs;
- However the underperforming Somerset CCG and One Gloucestershire ICS may receive marginally more;
- We wish to focus on key areas and not spread funding thinly;
- It's all about getting services better and each area has different challenges.

KH commented there was some concern re the level of detail but generally supported the principals.

JWR advocated honesty, openness and transparency. We need to work collectively across SWAG to improve services for our patients

The board supported these changes to the minutes 7 June 2019.

Two further slight amendments were noted (spelling 'principles' not 'principals' and attendance to include C Teller.

The minutes of the 7 June 2019 meeting were approved with changes as noted above.

JWR reiterated we are six months into the planning year and yet not where he would like the Alliance to be at this stage.

2. 19/20 Operating Plan and Funding

S Berry set out the overarching ambitions of the Long Term Plan (LTP) as:

- Diagnose 75% of cancers at stage 1 or 2 by 2028
- 55,000 more people will survive cancer for five years

She described the funding allocations for each of the Alliance deliverables as below. She reminded the board that SWAG needs to improve on staging data completeness.

Total funding is £5.73m.

Workstream	Alliance Funding (000s)
Sustainable Operational Performance	£2,540
Screening and Earlier Diagnosis	£2,000
Personalised Care	£300
Core Team	£600
Reserves and Evaluation	£292
Total	**£5,732**

For achieving sustainable operational performance, a definitive diagnosis needs to be given by day 28. It is vital that we diagnose cancers earlier and faster. This operational money needs to be dispersed and be used to improve performance. Providers were asked to submit plans to the Alliance programme manager.

3. Urology Area Network

Please refer to document (***Agenda Item 3 Prostate Funding 19.20 UAN Bid***) located here.

C Griffiths gave a brief overview of the Urology Area Network (UAN), which comprises SWAG providers NBT, RUH, Weston and a Thames Valley Cancer Alliance provider Swindon. The board were informed one of the key recommendations form the 'The Getting It Right First Time' national Specialty Report for Urology published in July 2018. was that UANs should be established in order "to provide comprehensive coverage of urological services, beyond existing network arrangements, to optimise quality and efficiency". The national review of urology services led to the conclusion that organising urological care on a trust by trust basis was unsatisfactory, as only a few trusts could offer comprehensive urology services in isolation. This led to the recommendation that UANs be developed, with the expectation that they will deliver:

- Increased efficiency of service delivery through the ability to balance workloads across different facilities within a geographical area and increased flexibility in the way in which people work and facilities are used.
- Improved cost-effectiveness as a result of optimising use of the skills of the clinical team, making best use of the available facilities and being efficient in equipment procurement and usage.

She acknowledges it is broader than cancer services but would like to work in collaboration with SWAG Alliance and test the water starting with the prostate cancer pathway. At this stage only the referral to biopsy element of the pathway, by building on the work already done to date with the SW prostate clinical leads and internally at NBT where they have reduced the wait to biopsy

to 12 days. Her proposal is the UAN accesses some of the Alliance funding approx. £250 for equipment, in house training and sustainable workforce to support the timed biopsy pathway.

CG acknowledged the UAN is still in its infancy. Presenting this paper late in the year was due in part to providers signing up to the UAN, Swindon had only done so last week.

RC reminded the board of the rules re use of revenue funding for capital bids.

JWR commented he could not see any figures in the paper presented.

AR commented that the work of the SW clinicians was an exemplar of working collaboratively across organisations.

The board agreed support in principal but wants to see a costed business case before approving. The business case will need to include providers sign up to purchasing the kit for future-proofing the services, and a check and balance re the funding rules for renting kit.

Action CG to provide costed business case to the Alliance

The board were presented with the indicative allocations for the prostate allocations:

STP	BNSSG	BSW	One Glos	Somerset
Indicative Allocations	368,741	275,000	243,883	212,376

Board members commented this was the first time they had seen these figures and asked had they missed a few months of planning time?

JWR noted these figures were new to the Board.

It was noted 3 SWAG providers were not members of this particular UAN, Taunton, Salisbury and Gloucestershire. In addition Somerset STP is part of two urology networks, but only the Bristol one currently exists.

J Graham asked if services not involved in the network should be offering something in parallel. P McLarnon confirmed they had approved in principle funding to support Taunton in delivering the new biopsy pathway.

P McLarnon confirmed that SWAG providers had already completed biopsy training or were due to go on courses imminently and therefore access to the new 2019/20 Alliance funds had not delayed progress with delivering the new rapid pathway.

4. Operational Performance Cancer

Please refer to document (***Agenda Item 4 SWAG Operational Performance***) located here.

The board acknowledged performance has dipped and 74.9% is a long way off 85%. There is a need to move forward; acknowledge it's not where we want to be.

5. Regional Update

R Carr provided a verbal update. There is an expectation that the Cancer Alliance leads the development of the plan in conjunction with STPs/CCGs/ICSs. BNSSG has been delegated as the CCG to submit the trajectories on behalf of the Alliance these are for numbers staged at 1 and 2 and for one year survival.

Key dates are first submission 27 September and final version 15 November 2019.

There will be a series of national WebEx's for using the early diagnosis tool and calculating trajectories.

The RDS plans are part of a regional assurance process and are to be submitted to the national team next week. Due to the financial amounts linked to RDS there is a robust assurance process in place.

Health Education England and NHS E have established a cancer task and finish workforce group.

RC has raised the risks of sustaining the SWAG personalised care (PC) services to the regional team. The national team are providing an OPD tool to support business cases evidencing the release of capacity in OPD by providing PC. They encourage expediting local evaluation again to support business cases.

JWR gave thanks for a helpful summary.

6. Cancer Operational Group

H Marder provided an overview of COG work programme, on behalf of all SWAG Cancer Managers and Lead Nurses. An update has been circulated as part of the board papers. Please refer to document (***Agenda Item 6 COG summary for CAB sept 19***) located here.

Particular concerns of the COG are sustaining the Personalised Care (PC) services and particularly the posts and staff who are at risk in the next few months. She noted this is a stark lesson that when setting up future services with two year transformational funding all are clear with regards pick up costs at the start.

D Goddard suggested a need to move projects to five year funding rather than two years; it is absolutely crucial to ensure a project becomes embedded and sustainable.

JWR stated that as the LTP is a five year plan and we have funding each year we have an opportunity to ensure all workstreams are costed and will be sustainable moving forwards. PC is part of the LTP ambitions; however cancer is now seen as a long term condition and so should be funded by core cancer funding and not transformation funding.

AJ stated his concern that the Alliance was falling into the same trap by using short term funding for pathway navigator posts which also will need to be picked up after Alliance funding ceases.

It was noted PC has had significantly smaller allocations in 2019/20 compared to other work streams, yet PC is as much a huge system change as early diagnosis.

7. Personalised Care and Support

Please refer to presentation slides (***Agenda Item 7 Personalised Care Report***) located here. D Goddard presented the national mandate for delivering PC, and the benefits to the system with all patients having access to Personalised Stratified Follow Up (PSFU), and the challenge of identifying how to sustain these services from April 20120.

KH commented that some fabulous work is being done but personalised care is at quite a delicate point in evolution and we do need to understand what happens next. Our 18 month programme to date is only the start of an evidence base and we would need at least 3 years more to evidence a full service model before knowing how to integrate as business as usual. Therefore there may be a need for additional Alliance funding from this year to support the programme and allow for a more tapered approach.

R Carr acknowledged it was great to hear progress but wanted to understand how the Alliance is performing with PSFU and remote monitoring. DG informed her that breast PSFU was implemented many years ago. Colorectal – 7/8 providers in the main following the agreed PSFU protocol; and the Clinical Advisory Group were close to agreeing the prostate PSFU protocol for implementation in 2019/20/21 if remote monitoring systems in place.

Providers have been asked for a baseline of their remote monitoring systems. £300K has been assigned for RMS set up costs but not all providers will need systems. J Curtis also highlighted that ongoing maintenance costs would need to be considered.

J Rimmer stated the need to be crystal clear about costs.

D Goddard stated more detail would be gathered following the Steering Group meeting to be held on Monday (9 September).

8. Early Diagnosis

8.1 Early Diagnosis

Please refer to the progress report (***Agenda Item 8.1 PED Report SWAG Board 6 September June 2019***) located here.

8.2 Prevention & Screening

Please refer to the Briefing Sheet (***Agenda Item 8.2 Cervical Screening Innovation Bids***_) located here.

The SW Cancer Alliances have targeted the cervical screening programme with interventions to improve uptake. Innovation bids were submitted by 100 SWAG practices. Bids were scored against the potential of plan to improve uptake, and address inequalities and variation. Screening uptake regionally remains low at 63.6%. There is £288K funding which equates to £2780 per practice on average. Successful practices will begin uptake initiatives in September 2019. There have been a range of ideas including additional staff funding and patient videos.

In addition to the improving uptake initiatives a directory has been developed which has captured as many of the activities that have taken place in the last 3 years, or are currently being delivered, to increase cancer screening uptake in the South West. This identified not only what projects are underway but where in the South West. As part of this work, the SW Cancer Alliances are also developing an interactive mapping tool, which will include the information gathered in the screening directory but layer this with other data at an STP and CCG level, to help us to understand the impact of our interventions and where we need to target local interventions in future. The mapping tool will be set against an Ordnance Survey backdrop and the content will change depending on the scale.

P McLarnon outlined there had been 100 bids across the SWAG region and from these the Alliance had selected 64. The focus was to look at innovation. Some bids which would receive feedback that they had been 'unsuccessful at this time' but would be requested to resubmit at a later date, because of the strength of bids.

9. Early Diagnosis – SWAG Rapid Diagnostic Services Progress

Please refer to presentation (***Agenda Item 9 RDS Progress Summary SWAG***) located here.

A Randle summarised progress to date. Approval to develop a business case has been given to four services that submitted an expression of interest. These offer a true system-wide approach and are exciting. The aim will be to follow on with Phase 2 quickly, to increase access, as these four initial offerings have natural close networks with other PCNs.

JWR confirmed this was a very exciting development and an opportunity to promote models nationally. The question was how do we spread benefits across the patch?

D Goddard said it is a question of demographics and would require a broad sweep including community hospitals such as in the example of BNSSG. There are some very rural practices who are working with community hospitals and current EOIs demonstrate quite a good spread.

R Carr asked what was being done in terms of staffing and systems that will need to link up. N Gowen confirmed that work is being done with a single acute provider. The expectation is that this will be included in November Business Plans.

10.

10.1 Public and Patient Engagement

Please refer to document (***Agenda Item 10.1 PPE Update***) located here.

There are currently five patient representatives' supporting the evaluation of the personalised care programme. They have attended many events across the Alliance including Health and Well Being events and primary care education sessions.

JH, the board patient representative commented that five patients is not a huge number of representatives for such a large Alliance. She directed the team to the video the Yorkshire and Harrogate Cancer Alliance had created, covering much broader patient engagement. The board remains conscious of a need to hear the patient voice.

JWR stated the need to take this concern on board and that everyone should work to identify 2, 3 or 4 patients who could be reps from each STP.

Action: KJ to share the video with PMcL

10.2 Equalities Plan

S Berry informed the board the focus was to be on people with serious mental illness and their access to cancer services. The plan is to work collaboratively with nursing directorate and mental health teams. She will update progress at the next board.

11. Site Specific Clinical Advisory Groups

Please refer to documents (***Agenda Item 11.1 SWAG_MDT_Reforms - _Information_To_Date***; ***Agenda Item 11.2 Recurrent Arrangements for SWAG Cancer Clinical Advisory Groups-Draft_HD***) located here.

H Dunderdale drew attention to the documents uploaded on the website and requested ratification from the board for arrangements. Acknowledgment was that Salisbury are part of SWAG but sits within the Wessex region. Ratification actioned.

J Rimmer noted the really valuable work done by the site specific groups and the level of engagement of clinical teams.

12. Priority Pathways Transformation Progress

Please refer to presentations (***Agenda Item 12 Timed OGD Pathway SWAG Board Paper Update August 2019 (002)***; ***Agenda Item 12 SWAG Transformation Report***; ***Agenda Item 12 SWAG Transformation Report (3)***) located here.

Prostate

The pathway transformation is progressing. Many providers are now offering a new safer and more tolerable biopsy by local anaesthetic. Not only is this better for the patient but the pathway is also quicker and so cancer wait times are improving. There has also been a programme of MRI image optimisation to enhance the decision to biopsy or not, enabling some men not to

have unnecessary biopsies. There are multiple ongoing training events for the clinical teams. There has been good progress made.

Lung

Providers have implemented a straight to test pathway for CT if a chest x-ray is suspicious of cancer speeding up the beginning of the pathway but there is still much work to do to meet the 28 day standard. All clinicians are engaged and champions for the implementation.

Colorectal

This is a new pathway project and Clinical Leads have recently been appointed. The review of colorectal services will be via both a data collection and a peer review visit. Progress will be shared at the next board.

JWR highlighted the huge amount of work being done and how helpful it is to have a report.

13. STP/ICS Reports

Please refer to the following documents (***Agenda Item 13 BSW STP Board Report 6 Sept 2019***; ***Agenda Item 13 BNSSG Board Report 6 Sept 2019 v0.2***; **Agenda Item 13 Glos ICS Board Report 6 Sept 2019 v.2**) located here.

JWR asked STP representatives to report on 'What's going well?', 'Where are the challenges?' and 'What are the risks?'

A Jennings presented the highlights for BSW. There are three CCGs currently, but reorganisation is underway to create one organisation. Performance challenges are recognised and BSW is leading the way.

BNNSG - 2WW skin referrals are a challenge and they would welcome any support from a regional dermatology network.

JWR referred to the paper on achieving diagnosis within 28 days for skin cancer. This was presented in summary at this point. Please refer to document (***Agenda Item 2 Skin Funding***) located here. JWR stated the board was not in a position to sign off funding at this time. RC confirmed that there was 100K allocated for improvements' in the 28 day standard for skin. JWR asked Hannah Marder to facilitate a plan for the dermatology funds outside of the board.

K Hall presented the highlights for One Gloucestershire ICS. The urology pathway is still very challenged and as they were not part of the Bristol UAN it was currently unclear as to how to access the prostate funding for any service development. There is a risk to the sustainability of the community cancer rehabilitation service and they are working to find a solution.

Somerset - Somerset continues to encourage system wide working across the 2 providers for the benefit of the Somerset population. The Rapid Diagnostics Service proposed by the Mendip PCN in collaboration with the RUH is an exciting proposal.

14. SWAG Organisational Development - Progress

Please refer to the presentation (***Agenda Item 14 SWAG OD CA board report sept 19 DRAFT***) located here.

A Mitchell-Baker presented progress against the organisational development (OD) plan agreed previously.

Work to clarify roles and responsibilities within STPs is ongoing. He noted these relationships and the Alliance governance will be tested through the Long term plan development process. He informed the board his work was almost at an end and he would share a clear OD plan for SWAG in a few weeks.

JWR gave thanks for his OD expertise. He noted there is still much for us to do to move all elements to green; however work to date has been really helpful, and we have a better structure now. He reminded the board we will need to revisit these to monitor progress.

S Berry also gave thanks to A Mitchell-Baker.

15. AOB Including Forward Agenda Items

AJ raised the number of members of the board; JWR informed the board Regional Medical Director Michael Marsh wants to review this and we therefore may need to restructure in the future.

JWR thanked everybody attending for their time and commitment and confirmed a meeting summary would be circulated in the next few days. He requested that future board meetings be extended by an hour.

16. Time and Date of Next Meeting

Friday 6 December, 10am – 1pm.
Conference Room 1,
Spire Oncology Centre South West,
300 Park Avenue,
Aztec West,
Almondsbury,
Bristol
BS32 4SY