

SWAG Cancer Alliance Board Minutes

Conference Room 2, Genesis Care Bristol (formerly Spire Oncology Centre South West), 300 Park Avenue, Aztec West, Bristol BS32 4SY

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
Tariq White	Cancer Alliance Managing Director	SWAG Cancer Alliance
Patricia McLarnon	Programme Manager	SWAG Cancer Alliance
Helen Dunderdale	SSG Support Manager	SWAG Cancer Alliance
Hannah Marder	Cancer Manager University Hospitals Bristol NHS FT	SWAG Cancer Operational Group
Ruth Hendy	Lead Cancer Nurse on behalf of LCNs	SWAG Cancer Operational Group
Ruth Carr	Regional Cancer Programme Manager	NHS England, South West
Helen Crick	Head of Delivery and Improvement	NHS England & NHS Improvement
Dr Elizabeth Mearns	Medical Director Systems Improvement & Professional Standards	NHS England & NHS Improvement
Nigel Andrews	South of England Programme of Care Lead for Cancer	NHS England
Jonathan Roberts	Consultant in Public Health, Screening & Immunisation Lead	Public Health England South West
Alison Wint	Cancer Clinical Lead	BNSSG STP
Gemma Artz	Head of Performance Improvement	BNSSG CCG
Andy Jennings	Head of Acute Commissioning Wiltshire CCG	BSW STP
Kathryn Hall	Associate Director, Service Improvement and Redesign One Gloucestershire ICS	Gloucestershire ICS
James Curtis	Cancer Manager Gloucestershire Hospitals NHS FT	Gloucestershire ICS
Terri Agnew	Cancer Manager	North Bristol NHS Trust
Jonathan Cullis	Clinical Lead for Cancer Transformation/Co-Chair BSW STP	Bath Somerset & Wiltshire (BSW) STP
John Graham	Consultant in Clinical Oncology & Cancer Lead Clinician Musgrove Park Hospital	Somerset STP
Rachel Rowe	Head of Long-Term Conditions	Somerset STP
James Sanders	Communications Manager	SW Clinical Networks
Jennifer Hepworth	Patient Representative	SWAG Patient Representative
Deborah Haworth	Regional Manager, Wessex, South Wales and South West	Cancer Research UK
Amy Smith	SWAG CAG Administrative Coordinator	SWAG Cancer Alliance Support Service
Apologies		
Christine Teller	Patient Representative	SWAG Patient Representative
Glenda Beard	Macmillan General Practitioner – Rotational BNSSG STP representative	BNSSG STP
John Graham	Consultant in Clinical Oncology	Somerset CCG
Katy Horton-Fawkes	Patient and Public Engagement Lead	SWAG Cancer Alliance
Sally Plumb	Service Specialist	NHS England
Ulrike Harrower	Public Health Consultant	Public Health England SW

Welcome and Apologies

JWR, Chair, welcomed everyone to the meeting, and apologies were noted as above. Dr Elizabeth Mearns and Tariq White (TW) were welcomed to the board. TW has taken over as substantive Managing Director of the Cancer Alliance. JWR gave thanks for Sunita Berry's hard work as interim Manager.

JWR noted with a new Managing Director there is an opportunity to reset and refresh this year. The Long-Term Plan for the next four years has been developed and it is now for TW, PMcL and the team to make that happen.

It was previously agreed that board papers should be published 2 weeks in advance. For this meeting papers were circulated 1 week before this meeting to allow for a board briefing of the new Managing Director. All members present agreed this was sufficient time and future papers will be circulated to the same timescale.

Action: Core Alliance team to publish Board papers 1 week in advance

1. Notes of the Meeting of 6 September 2019 including Actions

The following changes were requested to the minutes 6 September 2019:

- Page 4 indicative allocations for the prostate allocations. TW commented that allocations for One Gloucestershire (OG) and BNSSG figures had been transposed. The correct allocations are 368,741 for BNSSG and 243,883 for OG. JWR requested addition of a footnote in 6 September 2019 to record the mistake.
- Page 5 request from JC to delete the word 'days' following 74.9%

The board supported these changes to the minutes.

The minutes of the 6 September 2019 meeting were approved with changes as noted above.

Actions from the last meeting were then discussed as follows:

PMcL stated that the 2019/20 Operating Plan & Funding was on the Agenda for this meeting. Regarding Agenda Item 2 status following the last meeting, 7/8 providers have submitted plans; Weston has yet to submit plans. Progress is noted.

Agenda Item 3 Urology Area Network. The 1st draft of a costed business case was rejected as this included costings for Great Western Swindon. The deadline resubmission date of 28 November has passed. However, TW has met with Terri Agnew, Cancer Manager at North Bristol Trust and a two week deadline extension has been granted, so this item remains open.

Agenda Item 10.1 Patient and Public Engagement (PPE). The proposal that each STP should identify 2-4 patient representatives is ongoing. Item remains open.

JWR reminded the board that he changed roles at the beginning of September, to take up his post as Chief Executive of Somerset CCG. He continues to liaise with Acute Trust Chief Executives to discuss the position of Cancer Alliance Board Chair.

2. SWAG National Cancer Patient Experience Survey Report

R Hendy (RH) presented highlights from the most recent patient experience survey report. Please refer to presentation (**Agenda Item 2 SWAG National Cancer Patient Experience Survey Results SWAG Board 6 December 2019**) located [here](#).

The survey comprises 50 questions about the patient's experience from diagnosis through to aftercare. Over 7,000 patients made up the SWAG sample group and over 4,500 survey results were returned.

This year's results indicated a sustained if not cautiously improving picture. There was some fluctuation in numbers but not a lot of statistical significance to this. No results fell below the expected range; and the vast majority were in the centre range. Returns were fairly evenly split male versus female. However the majority of survey returns were in the 75-84 years patient age group and not so many in the younger age groups. To note commentary makes up a lot of the responses, as if hospitals do not have 21 or more responses to a particular question, they do not get an actual score. This is a challenge for some Trusts and for some tumour sites.

Achievement highlights include a 97% Alliance response for operations Q25 'Beforehand had all the information needed about the operation'. However only 62% of respondents 'feel general practice staff definitely did everything they could to support them during cancer treatment'.

Personalised care and support indicators reveal fairly consistent activity and impact. Access to support workers has impacted the overall experience and despite the financial climate, additional Clinical Nurse Specialist and Allied Health Professional posts have been created. The important contribution of local charities and Macmillan support regionally or these posts was acknowledged. It was noted development plans are underway for two new Maggie's Centres at Musgrove Park, Taunton and UH Bristol.

Some of the changes introduced by Picker include CCG reports in addition to the Trust and Alliance reports. The fieldwork time is being shortened and the next cohort deadline is March 2020. More substantial changes in methodology and timelines are expected from 2021, which should include more information about outpatients and immunotherapy. The comments section generates a 100-page report currently, which is planned to be worked into a thematic report. Whatever changes are made, it is expected that Picker will retain good comparability with previous surveys. This will help teams across the region to continue to share learning.

National shared learning workshop dates are still to be announced but RH is a representative on the national advisory steering panel and will circulate these.

Questions from the board included whether it is possible to analyse whether younger patients are proportionally under-represented, by different age groups and tumour sites. This is possible to a degree. There was discussion about how the survey is presented and whether younger people would be more engaged with an online or Twitter survey.

J Roberts (JR) asked if there had been any work to gather pre-diagnosis experience and experience of primary care. RH stated there has not been a lot to date.

AR confirmed clinical teams have the most to learn after patient's treatment.

RC stated a new under 16s survey is being developed by Picker. The national advisory group has been set up and Bristol will be involved. RC will liaise with RH to discuss further.

HD asked if the survey would be expanded for rarer cancers. RH confirmed this is part of ongoing work.

AR queried whether any other demographics, such as Black and Minority Ethnic (BAME), mental health patients or those with learning difficulties, were under-represented in survey results and whether this is proportionate to patient groups. RH confirmed both were represented on the national group so as to address this.

KH noted the need to explore how to make the improvements required in primary care experience and capture that across the Alliance. SH stated the option for each primary care practice to do a deep dive would be interesting.

JH, patient representative, felt that the richness of this information comes from comments and asked if all did a thematic review. RH confirmed each provider has a reviewer who can forward on particular themes to clinical teams. This is the most valuable information for teams to read through and is often built into additional work programmes, audit work or focus groups.

JWR thanked RH for presenting these results and for her role on the national steering group. He advised the board to acknowledge the cautious overall improvement in results, noted the support from third sector colleagues, notably Macmillan and other cancer charities and reminded members of the commitment for learning from each other. All results should be shared with the cancer groups, CCGs and STPs.

3. Long Term Plan

Sarah Warren (SW) presented the current version. Please refer to presentation (**Agenda Item 3 SWAG LTP Board Dec 6 2019V5**) located [here](#).

TW introduced the current version long term plan draft, stating that a couple of iterations had been submitted to the national team, although plans are subject to purdah currently. Process and stakeholder feedback had been discussed and TW aims to work with Alliance board members to make this plan a reality.

Challenges include getting Early Diagnosis embedded in the next four years. Benefits include knowing what core funding will be from January 2020 to 2024. TW will work with teams to allocate funds. These plans are draft at the moment, but the deliverables are non-negotiable.

SW stated third draft plans were submitted to national team on 15 November and there has been no feedback yet. Ongoing feedback is sought from the Alliance stakeholders to keep building and refining. There are plans to set up a working group to scrutinise plans in more detail. A workshop will be held in early to mid-January and by the end of January/early

February the more detailed programme will be defined. The Plan on a Page provides a brief but clear explanation.

Slide 7 highlights two trajectory projections. Assumptions are generous and there are stretching targets. The SWAG priorities focus on:

- Prevention
- Earlier Diagnosis
- Faster Diagnosis
- Timely & Appropriate Treatment
- Personalised Care
- Children & Young Adults

The national ambitions were discussed, and it was agreed preventing cancer is a key target area.

Smoking cessation remains a really important part of the prevention plan. However, focus should also be on working with partners to target obesity and weight management. Care is needed to link some programmes, such as cardiovascular disease prevention, with cancer work. JR noted from a Public Health perspective these are risk factors but the approach must be nuanced, particularly for patients diagnosed with cancer or a recurrence. There are links with Personalised Care for cancer and survivorship and Health and Wellbeing links.

J Cullis raised concerns whether clinicians are trained to have discussions about obesity. AR said these might not be raised if there were risks of damaging the patient-clinician relationship. SH stated Motivational Interviewing is part of core GP training. E Mearns said in her experience as a former GP, there are teachable moments. The plan calls for much wider links with local authorities and charities. It might be most fruitful to look at as part of the Early Diagnosis programme.

Patient and Public Engagement (PPE) is noted as needing attention; the aim is to strengthen this. There needs to be greater representation in project groups and making sure that communication is a two-way feedback loop and co-design with service users. The Alliance needs to develop the PPE strategy; SW agreed to link in with Katy and James Sanders. LM suggested piggy backing on the PPE forum established in the clinical networks.

KH believes it is how Alliance members work with patients. The board has patient representatives and it is important to defer to them. As a QI Lead, KH works to co-design services and there was a recent launch meeting for National Patient Voices, with best practice toolkits for service redesign based on patient feedback.

JH, patient representative, was pleased to see PPE being taken seriously but reminded the board of the need to draw from all SWAG experience and to be proactive. She noted the absence of the PPE lead Katy Horton-Fawkes, as she does not work on Fridays so is unable to attend board meetings.

SH was pleased to see health inequalities as an important part of long-term plans. There is focus on hard to reach groups, such as BAME and Learning Difficulties. There is rising awareness in communities, through the deployment of Cancer Champions who can demystify services and healthcare. There needs to be much more targeted work with Patient Participation Groups and Cancer Research UK facilitators. Primary care needs much more support and there

is an opportunity for this to be driven through Patient and Public Engagement as we need patients to engage.

D Haworth, attending as Cancer Research UK representation, reminded the board to contact CRUK or other charities, such as Talk Cancer. CRUK have done some work in the peninsula and are happy to target areas of deprivation or need. AR comment was that Cancer Champions are often those GPs or people who are engaged, and we need to target the hard to reach which are often in the most deprived areas and practices that are also the most pressured. A Wint said that Primary Care Networks (PCNs) have funding for link workers, and we need to harness these and educate about screening programme to get the message out.

JWR said J Hepworth's (JH) and C Teller's involvement, as patient representatives at board level, is very much appreciated.

JWR summarised that with the indicative funding for the next 4 years and the LTP ambitions the board now has a forward view and can plan properly. The region is focussing on all the national trajectories and the board should be mindful of the target that 55,000 more people each year should survive their cancer for at least five years. Timetables will be clearer following the General Election.

4. 2019/20 Operating Plan and Funding Progress

The agenda item (**Agenda Item 4 Operating Plan and Funding Progress SWAG Cancer Alliance Board 6 December 2019 v3**) was circulated to board members before this meeting.

The Alliance has seen a number of challenges during this financial year including a transition of three managing director roles; therefore managing financial allocations has been complex and not as timely as planned. There is now a substantive managing director who will allocate this year's funding accordingly and start to define next year's allocations, so these will be made available to systems as early in the new financial year as possible.

TW highlighted that in terms of total spend, just over £1 million remains unallocated, which includes £500,000 from the Rapid Diagnostics Service budget. JWR confirmed the underspend is to be allocated so that each STP receives a broad brush fair share allocation.

H Marder (HM) raised concerns that by agreeing underspend allocations on fair shares, not all STPs are starting from the same baseline; this could perpetuate inequalities. JWR replied we need to get back on track, we have learned lessons with funding allocations this year and we will agree collaboratively going forwards. We will allocate underspend recognising totals already received per STP and bring all to a level of fair shares allocation of the Alliance total.

The aim is to produce next year's funding plan in March and circulate for agreement. TW will talk with all regional colleagues to do this.

The funding allocations proposals for 2020/21 will be signed off at the next board meeting. RC reminded of the need to report to the National Programme Team.

JH, patient representative, thinks 10% of budget expenditure allocated for core team costs seems huge; an explanation and breakdown would be useful. JWR responded indicating this is a set national allocation level.

Action: TW to look at assigning unallocated budget, circulate to STP Leads and agree outside of the Cancer Alliance Board

5. Personalised Care and Support Funding 2020/21

Please refer to document (*Agenda Item 5 Personalised Care Support Funding 2020-2021 v4*) located [here](#).

Cancer Transformation Funding (CTF) for the programme is supporting the service delivery in 2019/20 mainly with service staff who are on fixed term contracts. These expire on various dates commensurate with when the two year period started for each post, generally between April and August 2020. The CTF as we know is for two years i.e. non-recurrent and future Alliance funding for the duration of the 5 Year Plan period has already been indicatively allocated. The sums involved show a gradual reduction in total funding as we progress through the 5 Year Plan period.

Part of the PC&S (LWBC) work is an evaluation to support making the case to commissioners to move to a recurrent funding arrangement. The original SWAG position expected CCGs to pick up almost all costs for service delivery (£1.7 p.a.) from April 2020. This represents a cliff-edge approach rather than a managed transition, and assumes that between CCGs and providers, the full costs will be able to be found in some way.

In recent weeks the NHSE regional cancer lead has confirmed that this is a position unique to SWAG, i.e. is a self-imposed position (and thus one that it is within SWAG's power to resolve).

We are still in an unresolved position but there is consensus from the SWAG commissioners that Alliance funding should be made available for at least a 1 year transitional funding arrangement whilst systems negotiate the long term solution with STP commitment to pick up thereafter.

Exact funding allocations for Alliance programmes will be confirmed in early 2020 if this principle is agreed by Board. However, based on current costs and known expansion requirements, an estimate is that circa £1M of SWAG funding will be required in 2020/21 as a minimum.

Moving to near-100% funding from CCGs from April 2020 is an approach that SWAG could continue to take however is a high risk approach.

JWR requested a 4 year tapered funding plan to be presented at the March 2020 board including a commitment from STPs to deliver PC&S as per the LTP going forwards.

JWR noted and celebrated the commitment from stakeholders to collectively work together to find solutions.

Action: DAG to present a 4 year tapered funding plan at the March 2020 board including a commitment from STPs to deliver PC&S as per the LTP going forwards.

6. Alliance Operational Performance

Please refer to presentation (***Agenda Item 6 SWAG Operational Performance for 6 Dec 2019 Board***) located [here](#).

TW updated the board and announced SWAG Cancer Alliance is now 8th of 18 Alliances nationally with 62 standard; therefore it must be noted there is further work to do.

JWR commented well done for all the progress made and acknowledged commitment to the transformation work and how also in broad terms results regionally reflect national trends.

From April 2020 the new 28 day faster diagnosis standard will be live and future board reports will include.

JR noted Head and Neck as the lowest performing tumour group. This is a complex tumour group and HM stated UH Bristol are piloting an early Head and Neck pathway and would be happy to share this with other Trusts.

7. Rapid Diagnostic Services Progress Report

Please refer to presentation (***Agenda Item 7 RDS Programme Summary SWAG***) located [here](#).

AR updated the board on phase 1 project activities. The two approved PCN services will go live from January 2020. On Tuesday 10 December 2019 there will be an evening event held in Bath for key stake-holders to share learning. AR advised interested members to contact N Gowen for further information.

As part of the phase 2 wave, EOIs have been invited with a submission deadline of 24 January.

The national team's intention is that every patient will have access to an RDS within the next five years. Therefore focus should be that all site specific referrals and pathways are met within RDS principles.

JWR reminded all that the RDS sets a really strong message of primary care and secondary care working together. This is a call to arms and we need to think of innovative ways of delivering this to our whole population.

KH stated that the innovation stages of a new service model will be more costly which is entirely normal and understanding of the health economics will be established as the service model progresses. KH acknowledged there are really high levels of enthusiasm for the second phase, which will offer 20-25% coverage.

SW confirmed that an evaluation plan is being developed by her team with an initial steering group proposed to meet end of January 2020.

8. Clinical Lead Report including Clinical Cabinet Report

Please refer to document (**Agenda Item 8 Clinical Lead Report**) located [here](#).

AR, chair of the Cancer Alliance Clinical Cabinet, summarised that the Clinical Cabinet first convened on 22 October 2019. There was representation from all 8 providers by cancer lead clinicians. The board consensus was the membership should be more multi-disciplinary to include a Lead Nurse but also CCG and primary care clinicians.

Focus was on discussing the long term plan, a strategy for cancer in older people and robotics use in prostatectomy surgery. The date of the next meeting is to be decided after this Cancer Alliance board meeting but will take place before the next Alliance meeting on 13 March 2020.

AR updated the board on the review of Alliance clinical leadership. With the reorganisation of NHS E & I and the publication of the LTP it was agreed the Alliance needed to revisit what the clinical leadership should look like and how it aligns to the new structures and LTP. To date these posts have been remunerated out of the core team funding but going forwards they will be funded for time specific work from the programme budget. So it will be for each project team to agree.

SH asked is the leadership for both PC&S and prevention and early diagnosis as is continuing?
TW agreed to pick up the plans for clinical leadership from 2020 onwards.

JWR thanked AR and summarised the need to extend an open invitation to nurses and CCG clinical leads. Further consideration of how multidisciplinary the cabinet is and ensuring engagement is needed. He reminded the board that the clinical cabinet should represent core constituents.

Action: AR to review membership of clinical cabinet

Action: TW to review clinical leadership approach

9. Regional Report

RC gave a verbal update of regional and national activities and plans for SWAG.

RDC Planning guidance has been published and included in the planning template due to be submitted in mid-January 2020. This asks for more detailed planning for year 2 2020/21, with a more high-level plan through to year 5 and need to include indicative funding. £13million funding is available for SWAG over 5 years.

Final MDT streamlining guidance has been published and Alliances' will be asked to audit. Colonoscopy surveillance guidance is published Alliances' will be asked to agree an implementation plan.

The national cancer programme delivery group chaired by Cally Palmer, meets monthly. Their focus is data completeness against the new 28 day standard. An 80% national target figure for data completeness has been set. In September, regional data was 56% complete, it is recognised this is not reflecting true practice as there are some technical glitches at provider level with uploading data to NHS Digital. RC made a plea for those providers to contact NHS D and resolve ASAP. HM queried whether there would be regular progress reports against data for the 28 day standard. Teams want to get submissions right before 'go live'. RC stated that the national data team would not allow sharing but access to own data should be possible.

RC acknowledged that UHB had been showcased to the national team for their performance.

Other areas of focus include reducing the number of patients waiting more than 104 days. There are more than 300 patients identified in the south west. There is to be a webinar to discuss how to improve this.

As mentioned in Agenda Item 2, an under 16s patient experience survey is due to be launched in the summer 2020.

The RUH participation with the cancer improvement collaborative concludes in February, with a national closing event.

Regarding the planning round 2020/21, the national team will set a template linking to LTP.

JWR thanked RC for a really helpful update.

10. STP/ICS Reports

JWR acknowledged the strength of STP engagement and asked for key highlights.

G Artz gave the BNSSG update and said good work is being done by the skin team at NBT. We are not where we want to be but are performing much better for two week wait. Urology is performing well for 62 day targets. There are growing concerns around gynaecology and work needs to be done with primary care in a similar way to the skin team. A Wint gave further information of other programmes of work, including the commissioning of symptomatic FIT testing with BNSSG the first to commission. Piloting of Enhanced Supportive Care continues and addressing inequalities with the Learning Disabilities population.

AJ presented highlights from BSW. He stated 62 day performance was worse as an STP; while the three main Trusts are performing better individually, performance is lower at some of the smaller specialist sites. This can be explained by the complexity of patients treated. JWR acknowledged shared pathways are always the biggest challenges. AJ continued by saying diagnostics and the demand for chemotherapy were areas for concern. Good work is being done with primary care, education and early diagnosis. Now three CCGs are merging into one, three Macmillan GPs will be inherited to make synergies.

KH and James Curtis (JC) presented a One Gloucestershire ICS summary. There is some activity planned in the diagnostics programme. In terms of performance, urology is a big challenge. KH thanked JC for his work producing some 'green shoots' analysis for urology. Work is being done around community health inequalities, with BAME women. The CCG has given a partial commitment in the tapering LWABC programme. This has secured some Macmillan posts.

Rachel Rowe gave highlights for Somerset. There is improved quality of both the colorectal pathway and the quality of referral. Taunton has made significant improvements to their prostate pathway with transition to a safer and more tolerable biopsy technique, which will in turn speed up the patient pathway. In terms of the funding of PC &S programme, STP discussion is needed but a decision on remote monitoring has been agreed.

JWR thanked teams for the helpful updates and noted two STP reports had picked up skin cancer so perhaps Alliance-wide awareness is needed.

11. Alliance Workstreams Reports

HM asked that all screening services be made aware of the new 28 day FDS

Action: HM to send to J Roberts

JH, patient representative reminded board members of a previous suggestion to find four or five patients from each STP area who could represent the patient voice. A Wint asked JH for guidance of what the role would be before considering recruitment.

Action: KHF to lead on SWAG PPE strategy

Action: HD to forward a list of patient representatives who attend Clinical Advisory Group meetings to KHF

Alliance Communications and Engagement: Website development is in progress. Contact James Sanders for more information

12. AOB including Forward Agenda Items and Tricordant Organisational Development

TW discussed Tricordant developments. TW has seen the draft report circulated at the last Alliance board meeting and met with Alastair Mitchell-Baker last week. There are plans to engage with the next phase, concerning governance and wider engagement. TW and JWR both discussed plans for two-tier governance: an executive group and an operational group. JWR stated the Alliance board's input at an operational level would continue but there is a need for more executive engagement.

JWR thanked everybody attending for their time and commitment.