Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance

SWAG Cancer Alliance Board Minutes
Microsoft Teams Virtual Meeting

Present	Title		Representing
Deborah Lee	Cancer Alliance Chair and Chief Executive Officer (CEO)	DL	Gloucestershire Hospitals NHS Foundation Trust
Tariq White	Managing Director Cancer Alliance	TW	SWAG Cancer Alliance
Dr Amelia Randle	Clinical Director for Primary Care	AR	SWAG Cancer Alliance
Helen Winter	Clinical Director for Secondary Care	HW	SWAG Cancer Alliance
Matthew Bryant	Operational Lead SWAG Cancer Alliance, Chief Operating Officer	MB	SWAG Cancer Alliance/Somerset NHS Foundation Trust
Bernie Marden	Trust Medical Director	BM	Royal United Hospital Bath NHS Foundation Trust
James Rimmer	Accountable Officer and Chief Executive	JWR	NHS Somerset CCG
Julia Ross	Chief Executive Officer	JR	NHS BNSSG CCG
Mary Hutton	Accountable Officer & ICS Lead	MH	NHS Gloucestershire CCG
Nicola Gowen	Programme Manager (Faster Diagnosis)	NG	SWAG Cancer Alliance
Robert U		RU	
Rosanna James	Deputy Director (Operations Division)	RJ	North Bristol NHS Trust
Tracey Cox	Chief Executive Officer	TC	NHS BSW CCG
Ulrike Harrower	Consultant in Healthcare Public Health	UH	Public Health England
Amy Smith	SWAG Clinical Advisory Groups Administrative Coordinator	AS	SWAG Cancer Alliance Support Service
Apologies			
Cara Charles-Barks	Chief Executive Officer		Royal United Hospitals Bath NHS Foundations Trust
Gavin Thomas	Executive Services Manager		Salisbury NHS Foundation Trust
Libby Walters	Director of Finance/Deputy Chief Executive		Royal United Hospitals Bath NHS Foundations Trust
Philip Kiely	Deputy Chief Operating Officer		University Hospitals Bristol & Weston NHS Foundation Trust
Robert Woolley	Chief Executive Officer		University Hospitals Bristol & Weston NHS Foundation Trust
Stacey Hunter	Chief Executive Officer		Salisbury NHS Foundation Trust

1. Welcome and Apologies

Deborah Lee (DL) welcomed all members to this SWAG Cancer Alliance Executive Cancer Board meeting. Introductions were given by those in attendance. A number of members could not be present due to national issues with MS Teams access.

2. Patient Story – Why We Are Here

DL confirmed that two patient representatives had been recruited to join the Board and she was very impressed with their insights and was looking forward to working with them. However, they were unable to join today due to technical issues. The Alliance team will work closely with them to identify patient stories or other matters relating to patient and public involvement, to present at the start of each Board meeting.

Action EB008: TW to liaise with patient representatives to identify a patient story for the next Board meeting

3. Notes and Actions from 30th September 2020

There were no amendments requested to the notes from the first Board meeting held on 30th September 2020. Notes are accepted.

Matters arising from that meeting are either closed or on the agenda today. There have been no updates or additional matters to raise.

4. National Cancer Patient Experience Survey 2019

DL reminded the Board that at the previous meeting the Patient Experience presentation had outlined highlights from comments. The Board had requested a revisit of the summary to get assurance of services making improvements where they had been performing less well. There are a number of providers regionally who show as outliers in results.

TW reminded the Board that across the Cancer Alliance, services have improved. However, 12 out of 480 scores were either equal to or below the expected range. As this is relatively historic data, the range of actions have been followed up within each Trust through governance routes and Cancer Steering groups.

It is understood that the NCPES is changing and the current year's survey is voluntary participation. Therefore it is currently uncertain whether it will be possible to track progress.

DL asked MB for clarification of whether the Delivery Group would get assurance of improvements. MB updated the Board that the Delivery Group is currently still forming. They will certainly have assurance but caution is needed not to add an extra layer of performance management alongside commissioners. Results should inform the work programme going forwards and MB is keen to hear from patient representatives.

MH highlighted that only 12 out 480 results being equal or below expected range is positive. Results should be seen in the context of other patient experience measures and all results should be measured on a continuum. DL agreed the SWAG Cancer Alliance is not a poor performing one, this is pretty good performance but reminded the Board that for a large number of results performance was average and supplementary follow up should be provided in context.

TC asked for clarification on the future nature of voluntary participation. TW stated that is was voluntary during the COVID pandemic but would revert to normal for 2021/22 and that NCPES team are still reviewing changing the structure of the survey and questions asked. The Clinical Operation Group would provide leadership on the survey

JWR stated it may be appropriate to check with other Alliances to understand other trackers.

5. Personalised Care and Support – Position Statement

TW stated in the last two to three years discussions had focussed on how to take Personalised Care and Support forward as business as usual for services. The Personalised Care and Support workforce were at risk due to uncertainty of funding. The Cancer Alliance has now agreed with all systems a four year tapered funding approach, where Alliance funding gradually decreases and system funding increases integrating the services into 'Business as Usual' activities. This would expand in line with national deliverables. Therefore all Personalised Care and Support funding has now been agreed; posts have been made substantive. Year 2 money will flow as agreed.

DL thanked all systems for their work in agreeing this.

6. Updated Terms of Reference

DL confirmed this item aimed to reach Board agreement for sign off of circulated Terms of Reference.

The Board discussed the level of primary care attendance needed at this Board meeting. Terms of Reference and the supporting Clinical Leadership paper, which was circulated, identify the need for a Clinical Lead for Out of hospital Care and a Clinical Director for Secondary Care, with both posts working closely together.

TW confirmed that historically AR had held the post of Clinical Director for the Cancer Alliance in a one day per week capacity. However, Cancer Alliance activities in the hospital and primary care settings have grown substantially in recent years.

Cancer Alliance activities now include oversight of the 14 Clinical Advisory Groups, all of which have Clinical Leads as chairs. There are separate areas of work in lung cancer and urology (most specifically prostate). Personalised Care and Support activities are supported by an Alliance lead; this post is currently vacant but will be filled in the near future. A Clinical Prioritisation Group of Cancer Leads within each Trust meets fortnightly but can be stood up as necessary; meetings were held more frequently during the height of the pandemic. The Alliance also holds Clinical Leadership calls every Friday morning, which are usually chaired by AR. These are all avenues which will provide input into the Executive Board meetings.

Due to the need to secondary care clinical leadership, Dr Helen Winter, Oncologist has been appointed as Clinical Director for four sessions per week. She is now in her third week working for the Alliance. AR will now focus on clinical leadership in the out of hospital sector. TW will work to support both directors through Alliance activities.

MB commented that getting appropriate clinical arrangements in place is hugely important to Board activities and thanked TW for this. The clinical voice should be right at the heart of Board strategy and focus. The balance of skills that AR and HW will be able to bring seems appropriate and there is concern about adding to Board membership further.

JWR agreed that AR and HW should represent clinical views at Board level. However, they need to contact appropriate clinical leaders to get the right input. DL agreed that both HW and AR will provide clinical input. AR should meet with Peter Brindle and Alison Wint, along with other primary care colleagues. TC commented that Ruth Graham from BSW should be included. A GP voice should come through AR's primary care focus initially and if needed the GP voice could be addressed separately in future.

JR reminded the board of the need to improve outcomes across the Cancer Alliance and primary care should be at the heart of this. UH highlighted there is a huge opportunity for prevention discussions. DL confirmed that the Early Diagnosis and Population Health Inequalities management groups' areas of focus should meet these needs.

DL concluded that with the correct infrastructure in place, the Board focus can then be on governance and strategy. Currently there are timing issues for when different groups meet and items are not necessarily filtering through to the Board. UH raised concerns that the Public Health Screening Team is likely to be embedded into NHS England soon and was concerned how the Board would link. The roles are likely to be very different and may not cover immunisation. DL understands this detail may pull from NHS England Specialised Commissioning. MB felt that there is a chaotic working environment currently. Board focus should be on prevention and 'at scale'. This will develop as groups get up and running. DL said people are in the key roles and on 19th May the Alliance Management team have an away day to review and confirm how they will work and best service the Board and wider Alliance members.

Action EB009: AR and HW to think about the primary care voice. Focus on empowering clinical leaders. Their points of view should be filtered back at future board meetings.

7. Update on Alliance Clinical Leadership

This item was discussed as part of the Terms of Reference discussion. See comments above.

8. COVID Recovery/Operational Recovery

NG presented a summary of validated data from Q3 2020/21, as well as January and February data for Q4.

From an operational position, 31D and 62D performance is now similar to pre-COVID. Q3 2020/21 data, shows poor performance against 2WW and 62D standards. 31D performance was maintained however.

In Q3 and Q4 systems are maintaining referral recovery, although SWAG benchmarks slowest to recover across England. Referral recovery range across the region is variable, with BNSSG at 85% and BSW at 95% of pre-pandemic levels. Lung, urology and skin are particular sectors of concern.

We are in a very good position regarding the backlog: performance is at 14% below for 62D and -7% for 104D. This will look different going forwards, as priorities to treat shift to increase elective care. Some improvement during Q4 2020/21 against 31D and 2WW but not enough to meet the standards. NBT and SDHFT are the most challenged in the 31D sector. 62D performance is fairly uniform; YDH is the only provider meeting the 62D standard. SFT is the most challenged.

Regionally compliance with FDS and 2ww data reporting is at 96% for Faster Diagnosis. Achievement of 75% FDS standard is variable and UHBW and SDHFT are the most challenged. This data will be published from July and the standard is live in October.

In January 2021 all providers struggled. February data indicates some recovery. 2WW for Breast services is a particular issue. NBT are at 27% and SDHFT at 16%. This is due to high levels of demand and staffing issues.

RJ indicated this is not just a Q4 issue but will extend into Q1 of 2021/22. Issues do pre-date the pandemic but there has been a knock-on effect in screening. This is compounding issues. There needs to be clarity about referrals. DL confirmed there is assurance from JR but asked whether services needed anything further from the Cancer Alliance. JR indicated that the biggest challenge is the workforce and in particular radiology staffing. NBT had reached out to other Trusts for Mutual Aid support but had found this was a regional issue. The Alliance, Clinical Prioritisation Group and service providers are all aware and keen to resolve this but there is no quick fix. RJ confirmed that NBT are growing radiologist/staffing retention strategies but are not keeping pace with issues. DL asked if Health Education England (HEE) may be able to assist. JR confirmed this would be a useful link.

TW stated the breast service issues had been discussed at recent Clinical Prioritisation Group (CPG) meetings. All Trusts are struggling. TW had liaised with a neighbouring Cancer Alliance who had held mega clinics. If NBT wanted to provide these, other Trusts had agreed that they may be able to release staff to run them. TW will discuss further with RJ outside of this Board meeting.

NG continued and indicated that in 2WW Lower Gastrointestinal and Upper Gastrointestinal services were particularly challenged. There are significant challenges around ‘straight to test’ capacity.

Poor 62D performance is related to some challenges pre-existing to the pandemic. Endoscopy services appear to be in a much better place now. Urology is a sector of concern; performance had been improving but percentage scores are now coming down again. Referrals are only at 80% of typical levels and so services expect a wave in the near future.

DL thanked NG for this summary and requested that alongside regional quarterly data, national average rates be included in future summaries.

NG also presented the Performance Improvement Steering Group work programme 2021/22. There are risks to sustained backlog recoveries and focus is on LGI, urology and poor performing rarer sites specialties. The focus remains on how backlogs impact patients. PTL management aims to ensure any harm is minimised and aligns with dedicated diagnostic capacity to deliver national timed pathways. The colorectal specialty is a particular area of focus.

JR asked for clarification on how to capture outcomes against clinical standards while focusing on health inequalities. DL confirmed this work sits within a separate workstream whilst having interdependency.

MB raised the importance of having a balanced scorecard that is fit for purpose. This should focus on the 4Ps, i.e. population, patient experience, people and performance. The Performance Improvement Group will be important in addressing issues. While the Executive have a role to play, this Board's focus should be on strategic requirements and awareness of good practice, designing bespoke interventions and facilitating Mutual Aid. The sustainable workforce issue does need to be developed with HEE.

JR felt there is a need for triangulation and DL agreed that the Board should seek common solutions. The Board will focus on differential performance, particularly sharing best practice. Other performance issues will be dealt with by the Performance Improvement Group. DL requested TW invite Health Education England to join the Board.

TW stated that the monthly Performance Improvement Steering Group has a standard agenda item focusing on sharing best practice.

AR raised concerns that there are often conflicting priorities between performance and health inequalities. Health inequalities are often labour intensive, as has been shown through the COVID vaccination programme. This has been a significant learning tool in how to achieve both. DL agreed that aims around performance and the Alliance agenda would include the wider system.

Action EB010: TW to liaise with other Cancer Alliances to identify what role the SWAG Cancer Alliance could have in workforce retention/development.

Action EB011: National (i.e. England) average performance rates to be included in data summaries

Action EB012: TW to liaise with other Cancer Alliances to identify Dashboards and Performance scorecards for SWAG development and implementation

Action EB013: TW to invite a member from Health Education England to attend Board meetings

9. Operational Planning 2021/22

TW informed the Board of operational plans for the current financial year.

Priorities were agreed on 25th March 2021. Specifically, systems should plan to:

- Return the number of people waiting for longer than 62 days to levels seen in February 2020 (or to the national average where lower)
- Meet the increased level of referrals and treatment required to address the shortfall in number of first treatments by March 2022

There are three over-arching aims for cancer in 2021/22:

- To ensure cancer services are fully recovered following the COVID-19 pandemic and address the reduction in the number of people who should have started treatment during the pandemic
- To use recovery as a springboard to renew improvements in operational performance against the Cancer Waiting Times standards
- To continue to drive delivery of the Long Term Plan ambitions for cancer

The Planning Guidance clarifies that the £1bn Elective Recovery Fund will support delivery of the priorities for cancer and that systems should not view funding as a constraint in delivering as much activity as possible next year, including for cancer.

TW confirmed the Alliance is working with systems to complete the planning template and receive them by 30th April. The Alliance team will pull them together into a single draft plan document by 6th May. In parallel the trajectories and narratives are expected by 6th May. From that date until 3rd June, the Alliance will have conversations with systems about how these plans can be improved and strengthened. These will be linked into regional planning groups.

DL stated all services are wrestling with the planning challenge. MB reminded Board members that cancer should have visibility in all teams involved in planning. The Cancer Alliance could pick up with each system where inequalities are and workforce issues. System level plans should also include areas such as endoscopy and radiology but there will be variations across the region. Somerset CCG focus for example should include Diagnostics and the Board needs to oversight of how system plans are rectifying known problems.

10. SWAG Finances

TW summarised from the ‘Enc 8 SWAG Finances 2021’ circulated before the meeting. Funding allocations cover three areas:

- Service Development, including core team funding
- Rapid Diagnostic Services funding

- Innovation funding

Funding for 2021/22 is to be used to support COVID recovery and re-focus on the delivery of the cancer elements of the Long Term Plan.

£4.2 million has been allocated for Service Development Funding. A total of £2.14 million is broken down to allocate £1 million for Personalised Care and Support and £573,000 for the core team. Cross cutting allocation of £562,000 will be allocated for activities such as Cancer Research UK facilitators, Early Diagnostics work, Clinical Advisory Group support, Business Intelligence/Data/Programme Management, Clinical Leadership and Genomics. The remaining £2 million will be allocated to systems.

System elements will be broken down and allocated to systems on a fair shares basis based on populations. Therefore BNSSG will be allocated 34%, BSW 24%, Gloucestershire 22% and Somerset will receive 20% due to the smaller population.

Just over £3.3 million has been allocated for Rapid Diagnostics Service Funding. The top slice of £668,000 (20%) will be allocated for Cancer Alliance transformation projects related to this, if agreed by the Board. As an example, the GP Decision Support Tool was funded across the Alliance last year from this cross-cutting allocation. £2.6 million will be given to systems to spread Rapid Diagnostics Services equitably at a regional level.

A total of £222,000 is allocated for Innovation Funding. This is very specific allocation and will be given to two pilots for Cytosponge this year: one at RUH in Bath and one at GICS in Gloucester.

Funding will be released in two parts and BNSSG CCG will continue to host Alliance finances. TW understands additional National funding will also target a Targeted Lung Health Clinic for each Cancer Alliance. Discussions are ongoing to identify which system will host; this is expected to be agreed by the end of April.

AR confirmed there were discussions held yesterday, 26th April, about the Lung Health Check clinic. The aim will be to provide to the most deprived populations. The ambition is to deliver a SWAG-wide service delivered locally at the most deprived Primary Care Networks by one central team. DL commented that the idea of one centralised service would be ill-conceived when aiming to reach the most deprived populations; therefore, the suggested SWAG approach could be most beneficial to patients. She asked for clarification of where future conversations would take place. AR confirmed this would be through the Early Diagnostics forum and would also be discussed at the Clinical Leads group.

DL summarised by thanking TW for delivering the plans and systems for their support at every level.

11. ICS Development and How Cancer Fits

DL summarised her discussions with Michael Marsh and the recent white paper. This references the importance of good relationships between the ICS Boards and Cancer Alliance Boards. In the SWAG region, those already exist, enabling strong and effective communication; in some regions that is not the case. However, the proposed Provider Collaboratives and Cancer Alliances are distinct and separate.

Funding streams will remain ring-fenced to the Cancer Alliances. However, local systems can provide flexibly additional funding. DL and TW recognise this is unlikely under current circumstances.

JWR stated there is a need to keep cross-boundary working. DL agreed and ICSs are largely established both as West of England and as the South West.

12. Any Other Business

DL had not received any further items for discussion prior to the meeting. There were no further items raised at this meeting. DL thanked all members for their contributions and participation.
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