NHS
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	AR	SWAG Cancer Alliance
Matthew Bryant	Operational Lead SWAG Cancer Alliance, Chief Operating Officer	MB	SWAG Cancer Alliance/Somerset NHS Foundation Trust
Patricia McLarnon	SWAG Cancer Alliance Manager	PMcL	SWAG Cancer Alliance
Evelyn Barker	Deputy Chief Executive and Chief Operating Officer – Andrea Young CEO	EB	North Bristol NHS Trust
Philip Kiely	Deputy Chief Operating Officer representing Robert Wooley CEO	PK	University Hospitals Bristol & Weston NHS Foundation Trust
Jonathan McFarlane	Consultant Urologist, RUH Cancer Lead deputising for Cara Charles-Bark CEO	JM	Royal United Hospitals Bath NHS Foundation Trust
James Rimmer	Accountable Officer and Chief Executive	JWR	NHS Somerset CCG
Mary Hutton	Accountable Officer & ICS Lead	MH	NHS Gloucestershire CCG
Peter Brindle	Medical Director of Clinical Effectiveness, Chair BNSSG Cancer Board	PB	NHS BNSSG CCG
Tracey Cox	Chief Executive Officer	TC	NHS BSW CCG
Kathryn Hall	Programme Director, Service Improvement and Redesign One Gloucestershire ICS	KH	NHS Gloucestershire CCG
Susan Blake	SWAG Cancer Alliance Assistant	SB	SWAG Cancer Alliance
Amy Smith	SWAG Clinical Advisory Groups Administrative Coordinator	AS	SWAG Cancer Alliance Support Service
Apologies			
Julia Ross	Chief Executive Officer		NHS BNSSG CCG

1. Welcome and Apologies

Deborah Lee (DL) welcomed all members to the first new look Cancer Board for the SWAG Cancer Alliance. Introductions were given including the role of each attendee in the meeting. DL noted all systems were represented with a good mix of commissioners and providers.

DL advised the board today will focus on our modus operandi, terms of reference (TOR), and how we will work together to ensure that each level of the Alliance is operating effectively. TW will lead much of the conversation today as his is a pivotal role in the Alliance, however as we

develop, we aim to distribute leadership and have participation and contributions from all Board members.

2. Feedback from systems on Design and Governance of the Cancer Alliance and item 3. Terms of Reference for Board and Delivery Group

TW informed the board the first draft proposed governance arrangements were shared with chief executives and accountable officers approx. 6 weeks ago; amendments were made and second draft shared with all organisations for wider consideration. Feedback has been generally positive, and an executive level board is considered the right direction of travel. Initial high level feedback with regards this Board's membership is it is secondary care focused; however part of this reasoning is that the current TOR do not articulate the broader membership which is part of today's discussion. Also raised was the need for effective primary care representation and more broader clinical input at the Board.

Board members reviewed the TOR, and operating structure showing the relationship between this Board and the structures that sit below and will service this Board, and the design principles (slide 9) the Alliance will work to:

1. The Alliance will avoid duplication of work where possible by aligning with other key programmes and governance structures (ICS/STP, commissioning boards)
2. The Alliance will be localised where appropriate, and will balance representation from
3. the STPs and Integrated Care Systems.
4. The Alliance should work to improve quality of cancer care delivered in its footprint.
5. The Alliance should work to reduce variation of cancer care delivered in its footprint.
6. The Alliance should support beyond the patient pathway (i.e. It also needs to consider the population 'not (yet) in the system')

The new structure will comprise two main forums: this executive level Cancer Alliance Board; and the Cancer Alliance Delivery Group. TW noted not articulated yet is the structure of working groups which will sit below, as the co- design of the working groups will take place over the next few months.

JWR expressed general support for the principles but asked with regards to reducing variation which we have made significant achievements in clinically, where does performance sit within it? Are we looking to move patients across systems to support performance or do we look and monitor as an Alliance only? TW responded that the Covid response SWAG Clinical Prioritisation Group (CPG) currently does monitor patients waiting times as 14/31/62/104 days for diagnostics/treatments and does consider the need for mutual aid. Specifically for surgery there is a formal standard operating procedure in place for SWAG; however this has yet to be tested, which could be soon with the second spike. TW asked do we want to explore this concept of mutual aid beyond Covid.

DL responded that we want all patients to have equality of access and opportunity of outcomes and if mutual aid enables us to achieve this then it should be part of the future operating model. She asked that the Operational Delivery group give thought to how we address this.

PB stated that he wasn't sure the quality and variation aspects of the design principles are reflected in the purposes of the various committees. More specifically he noted quality isn't referenced in the governance document again and questioned what we mean about quality and performance. Cancer wait times (CWTs) are under scrutiny, clinical outcomes are important and engaging clinician's in conversations with regards CWTs is difficult but engaging them in terms of performance improvement in terms of clinical outcomes is easy, therefore there needs to be more specific reference to them. His view is that we should be looking at CWTs in parallel with outcomes and reducing variation in those outcomes.

DL asked the board to go back to slides 6 and 7, the vision and purpose which she feels is very patient centred and quality and outcome focused, but sparse on performance management.

MB drew the board attention to slide 5 which states that a good Alliance should have 80% of its focus on transformation; therefore transformation of quality of clinical care and improved patient experience and 20% on performance and feels this is a good balance to strike as this board moves forward.

DL agreed with both PB and MB, and her personal approach to performance is that it is helpful because if we improve performance, we improve patient experience, and on some pathway's outcomes with the delivery of rapid access. So we should continue to remind ourselves as to why we want to see continual performance improvement, and not just see it as dashboards or RAG ratings.

DL stated that once the governance approach is supported, we will agree to strategic objectives we can monitor our Board progress against in the format of a Board Assurance Framework.

TW summarised the TOR. The main purpose of the Alliance Board is to provide direction and strategy, set priorities and support the Alliance team and hold us to account for delivery. Importantly the Alliance will act in the best interest of the SWAG systems and population. Section 2 outlines the duties of the Board. Section 3 outlines the membership which comprises Alliance Chair, MB as Alliance operational lead, AR Alliance clinical director, TW Alliance managing director, CCG Accountable Officers and Chief Executives from each provider.

Discussion for today is what other representation to be want and how often will we meet.

A specific challenge from the SWAG CPG is that the bar is set high for executive representation but the quoracy is set low.

DL asked as Chair for all to bear in mind we need to contain membership to a manageable number, but yes, we do need the right balance of clinical representation.

Views of the Delivery Group membership:

MH view is that membership should reflect the priorities in our workplan which include being a conduit to Primary Care Networks (PCNs) for early diagnosis and personalisation, so how do we achieve that in our membership? Could we have a clinical champion that brings the early diagnosis and personalisation? We already have good system level primary care leads, that could combine the clinical perspective and our priorities within primary care.

DL agreed the need to build primary care representation into the membership.

KH asked the Board to consider the cancer manager representation. The proposed membership is one cancer manager representing the views of a broad and diverse group of busy people and asked do we feel that will work well? Should we have one cancer manager representing each system?

MB responded that essentially, we are not currently sure of how we address, initially we need to take a quality improvement approach and evaluate as we develop. The board will not be the only way in which cancer managers, lead nurses and primary care etc are involved in the work of the Alliance, and we do need to consider the size of the board and delivery group. MB agreed to think about it outside of this meeting. He also highlighted the need to consider patient representation and expressed the view the Delivery Group should be empowered to agree the best way to bring the patient voice into their working, and that we should hardwire having a patient story in the Delivery Group to ensure access to a wide range of patient voices.

EB stated there needs to clear guidance in the TOR as to responsibilities of those on the delivery group of how they engage with other providers and communicate out.

AR expressed her view that there are 2 levels of primary care engagement. There is the clinical voice which we are well engaged with but there is also the strategic representation from primary care and feels it should be that that is represented on these boards.

PB stated this is also a great opportunity to develop and coach our trust level orientated cancer managers and lead nurses into a system approach.

TW asked was the Board in agreement that the core team would agree with the delivery group the working groups that would sit below, and the Board agreed.

It was agreed that future meetings would be held on a quarterly basis, as close as possible to publication of quarterly data summaries so these could be reviewed in real time.

DL thanked the members for their views and confirmed DL, TW and MB will rewrite the TOR and present at the next Board meeting.

Actions:
DL, TW and MB will rewrite the TOR and present at the next Board meeting

TW and MB to agree with the Delivery Group the working groups that will sit below
TW to assess patient representative attendance at Board meetings

4. Overview of Phase 3 Plan

TW presented the slides circulated and asked the Board to focus on slide 10 the plan on a page, and gave highlights of the 3 key priorities for recovery:
Aim 1: To restore urgent cancer referrals at least to pre-pandemic levels
Aim 2: To reduce the backlog at least to pre-pandemic levels on 62 day (urgent referral and referral from screening) and 31 day pathways
Aim 3: To ensure sufficient capacity to manage increased demand moving forward including follow-up care

He noted there will be particular focus on lung cancer recovery, where referrals are currently 55% below baseline, and development of the Rapid Diagnostic Services.

AR stated that a PCN DES virtual event is due to take place from 1pm today, it will be a community of practice with secondary and primary care discussing lung cancer referrals specifically.

DL acknowledged this is a massive agenda and the role of this Board will need to be really clear on priorities and that we are here to manage matters of escalation and we will think about how we celebrate success but importantly we need to focus on areas where we are not making the progress we need to.

TC asked had the Alliance team been involved in setting the systems 62 day recovery trajectory (post Covid) and TW confirmed the core team were not. DL expressed that this was a good example as to where the Alliance could add value, as if we understand the trajectories of each system plan, we will understand where we can give support in either shared learning from a system that is achieving or our expertise to support achieving.

Summary:
DL we really need to identify what the added value of the Alliance is and what we can bring to individual systems to support them.

5. Cancer Performance across Systems and Alliance

TW presented a summary of SWAG and STP performance during Q1 2020/21. He noted the performance was arbitrarily RAG rated: green identifying where systems are performing within or better than target; amber identifying areas where performance is within 5% below target; and red is where performance is 5% or more below target to stimulate discussion.

General areas of concern across all systems are around 31 day waits for subsequent surgery, 62 day waits from referral to treatment and 62 day waits for treatment following referral from a screening service. Comparison was also shown between Q4 2019/20 and Q1 2020/21 to highlight the impact of Covid.

DL commented that its helpful to see in this way, presents where we need to put our focus in the Delivery Group level, and reminds us that improving performance will lead to a better patient experience and improved outcomes. She stated for this Board being a day away from the end of Q2 it was not important to dwell on content presented but note that all systems had shown a big movement in performance during Q2.

DL stated that future Board meetings pattern would be held as close to quarter end as possible to review performance and act on areas for concern to drive up improvement.

Feedback was sought on how this information is presented to the Board.
PB expressed that this is helpful, but what would be more helpful is a summary; these are helpful composite measures, but we need to identify common themes across SWAG e.g. urology and 62 day systems and understand is it common to the whole of SWAG or specific to one system or provider; so more specifics about the general themes.

EB suggested we have data on referrals so as to continue to consider the unmet hidden cancers out there.

DL agreed and stated we need to move on from data to knowledge, and for future reports we will include contextual measures, referral rates and cancer registrations. We will also respond to PB request but noted we will of course be reliant on individual providers and systems to share their insights around successes and challenges.

TW reassured the Board that performance is reviewed weekly by the CPG also and we know that detail.

DL stated we really need to focus on the value add as an Alliance, we are not here to observe mediocracy, we are here to drive improvement.

Action: TW and MB to agree content of performance report for the subsequent board.

6. Overview of Finances

TW presented the funding profile for 2020/21. We are allocated a total of 7.24m, made up of 4.2m service development funds (SDF), of which 0.6 is for the running costs, 2.59m for the Rapid Diagnostic services and some funds for the colon capsule endoscopy initiative and other innovation funding. BNSSG are the host CCG and hold the funds (minus core team) on your behalf and the core team funds sit in NHS England.

Our working assumption relayed by the national team for this year was that due to Covid, for Q1&2 the SDF was in block contracts as calculated from month 9 2019/20; therefore the expectation was that approx. half of the Alliance funding was already in systems in block contracts. However there was a communication from the regional team just yesterday to system

directors of finance, and this appears to be confirming that no cancer monies were within the block contracts, so our working assumption is now that we will receive the full year effect of 7.24m. We will confirm funding through the phase 3 planning processes this week.

Summary
Board members saw it as good news that full year funding would be available shortly. DL confirmed it is positive, but funding allocation remains a work in progress which needs to be developed considerably.

Action: TW confirm Alliance funding
Action: TW and PMcL to work on apportioning funding

7. National Cancer Patient Experience Survey (NCPES) – Overview of Results

TW presented results from the SWAG NCPES survey taken between April to June 2019 and thanked Ruth Hendy, Lead Cancer Nurse at UHBW Foundation Trust for preparing the slides.

A total of almost 3,900 patient results were collected in the SWAG region; a 66% response rate. Highest scores included access to named CNSs, access to support and self-help groups and being given the right information about their treatments. Lowest scores are higher than the national average but may need action planning at future board meetings. These include discussions about cancer research, provision of care plans, and support from health and social services after treatment, and management of the long term consequences of cancer treatment.

There has been significant improvement in patient experience across the region between 2017 and 2019. In 2017 a total of 56 responses above the expected range; in 2019 that increased to 80. The number of responses below expected range has reduced from 21 to 12 during this time. The board noted the most significant improvement in patient experience has been at Weston between 2018 and 2019 and gave their congratulations to the staff at Weston.

Also presented in the data is those questions that are above the expected range and how they map to our personalised care and support services (PCS). TW highlighted that as a success but also the risk to the sustainability of that workforce, and therefore our ability to further improve performance. Discussions are ongoing with SWAG commissioners as to how we support these services going forwards.

DL asked that we showcase on a regular basis great work systems are doing to both share learning but also celebrate success. She stated its unusual to see such a positive correlation between a set of actions and initiatives and the dials moving as markedly as these have done. You have flagged the major risk, and we acknowledge many of our support workers are on non-recurrent funding streams and are feeling vulnerable as to their employment status, so we need to address that, and it is predominantly now linked to SDF. So key to this is landing the allocation of SDF for this year.

TW informed the board of the four year tapered funding approach agreed at the last Board meeting in March 2020 to support the personalised care programme, and this was under discussion with the commissioners. DL agreed we should continue with the tapered funding proposal as the Alliance should be putting transformation funding at the front end, developing innovations until ready to prove their worth, and enable a business case.

MB made a plea to the board to be mindful of the people in these roles, and universally within SWAG give them certainty of employment. DL asked that the Delivery group seeks a position statement from each system so the Board understands the status of their workforce, and stated if necessary, trusts may have to go at risk, as they had in Gloucestershire NHS Foundation Trusts just last week to sustain this workforce.

DL asked that for the next Board meeting a brief on the 12 responses that were below expected range so that we can agree what the Alliance can do to help address.

Actions:
Delivery group seeks a position statement from each system, so the Board understands the status of the PCS workforce
TW presents a brief at the next Board on the 12 responses that were below expected range

8. AOB

There were no further items for discussion at this meeting. DL thanked all for their contributions and participation and asked for any feedback about the nature of the meeting, content and materials and her approach to chairing so as to make the meeting successful for all.