Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance

Paper Title							
Clinical Leadership in SWAG Cancer Alliance							
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Executive Summary							

Purpose

This paper presents the current Cancer Alliance (CA) clinical leadership arrangements within SWAG, and proposals to enhance clinical leadership to go further in supporting COVID-19 recovery and delivery of the Long-Term Plan ambitions beyond Covid-19.

Background

The NHS Long Term Plan highlights the importance of visible senior clinical leadership in enabling clinical transformation and assuring the delivery of high-quality care, both within organisations and in the new system architecture.

Current clinical leadership structures include:

A Clinical Director role (2 PAs a week) who provides clinical leadership across the system (primary and secondary care) but capacity to undertake this role is limited in the time available. There is growing recognition that the work of the Alliance in the 'out of hospital' setting has been growing steadily over recent years, with the focus on early detection of cancer and the advent of Primary Care Networks (PCNs).

14 Site Specific Clinical Advisory Groups (CAGs). These are organised by the providers of cancer services (funded by the CA) and chaired by clinicians. These posts are not remunerated. Their purpose is to improve patient care, provide assurance of compliance with the Quality Surveillance Programme for Cancer, and provide expert advice and guidance on the standards of cancer services.
The CAGs are varied in their structure, leadership and extent to which their priorities are aligned with those of the Cancer Alliance. Providing CAGs with more direction and support has been highlighted as a key priority for clinical leadership. The CAGs are accountable to the Cancer Alliance Board and its member providers. However, the route for this to happen is unclear and needs to be strengthened. Acute providers of cancer services have an ongoing responsibility to run the CAGs and Commissioners have a responsibility to consult with the CAGs and respond to issues raised by the groups as set out in Appendix I.

There is also a Clinical Leads group which meets twice a year and is comprised of all the CAG Chairs. The purpose of the group is to share innovations and learning across the CAGs

In addition the Cancer Alliance funds/funded some additional defined and time limited roles to drive transformation of pathways; these are:

- Lung Cancer Lead 4 PA's per month
- Urology (prostate) Lead 1 PA per month
- Urology (prostate) Radiology Leads 1 PA's per month
- Urology (prostate) database Lead 0.6 PA per week
- Clinical Lead for Personalised Care & Support 4 PA's per month (post vacant due to retirement March 2020)

The above roles and activities are reviewed on a quarterly basis

Finally, there is a Cancer Operational Group (COG) of operational and nursing leadership from the seven local acute provider Trusts, who work collaboratively to ensure all activities that influence the effective and efficient delivery of cancer services are considered.

In 2019 SWAG CA participated in an organisational development project led by the consultancy firm Tricordant, as part of a nationally commissioned project to improve CA systems leadership and governance. During this work, a need to connect better with frontline clinicians to strengthen the coordination of the clinical voice and leadership was identified. The Tricordant development plan for the Alliance highlighted transformational objectives to facilitate clinical collaboration and pathway management:

- establish a clinical cabinet with senior representation from STP/ICS, primary care and secondary providers, linking into the SWAG Site Specific Clinical Advisory Groups (CAGs).
- Co-ordinate and encourage collaboration to overcome system constraints to deliver quality services
- Facilitate clinical groups, to develop pathways, protocols, patient guidelines, keeping up to date with national guidance/clinical guidelines
- Searching out good practice, peer learning opportunities
- Facilitate more joined-up services and sustainability, e.g. services for rarer cancer sites where multiple providers operate but lack population critical mass & struggle with the workforce.
- Ensure that pathways reflect patient and public feedback

In response to the COVID-19 pandemic the Alliance instigated two new clinical groups. The first is the Clinical Prioritisation Group CPG) which has clinical oversight of surgical, and non-surgical treatments and diagnostic cancer activity across the Alliance. Its purpose is to ensure equitable treatment of patients with cancer and initiate mutual aid when required. It meets weekly, is chaired by the CA clinical director, deputised by the Cancer Lead Clinician for UHBW, and membership is all cancer lead clinicians of each acute trust.

The second group is the Clinical leaders Call. Initially set up as a source of

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information and support during the Coronavirus response, these calls have evolved into a forum for shared learning and collaboration during the recovery phase. The calls provide a responsive and diverse forum for clinical engagement.

Both groups will be reviewed as we exit Wave 2 of COVID-19 to see if they are still required or evolve into something different

Priorities for clinical leadership in SWAG have been identified by the Clinical Director and are highlighted in Appendix 2. These are areas where we need to see clinical leadership but may not need a defined role

Recommendations

- The Alliance wishes to strengthen leadership in secondary care and harness the clinical expertise within the CAGs more effectively.

- The Alliance wishes to strengthen leadership in the Out of Hospital setting and to engage with Primary Care Networks more effectively.

In order to achieve these two goals we are proposing to:

- Appoint an Alliance Clinical Director for 4 PA's per week who will act as advisor to the CAGs and have as a key part of their remit working closely with secondary care providers, including the Clinical Directors of Secondary Care, and where appropriate Medical Directors/Chief Medical Officers. This post will be a member of the SWAG Board, and will make an important contribution to the strategic leadership of the alliance. They will be a core member of the SWAG senior leadership team, reporting to the Managing Director and having a professional leadership reporting line into the SW regional team.
- Refocus the current Clinical Director role to be the Clinical Lead for Out of Hospital Care for 2 PAs per week to act as advisor to Primary Care and its leaders and have the authority to influence; and to be a member of the SWAG Board. This post will also report to the Managing Director and have a professional leadership reporting line into the SW regional team.
- Create a clinical forum for CAG Chairs and CPG members, chaired by Clinical Director to advise the Board on matters of clinical strategy and clinical priorities. This clinical forum relates to the Clinical Cabinet referred to in the Tricordant work and wider membership may need to be considered
- Create a clinical forum for Out of Hospital Care
- Identify leads for priorities listed in Appendix 2 either in funded roles for the alliance or as part of their existing role
- Continue with CAG and Clinical Leaders Calls through the recovery phase

It is recognised that there may be HR implications for current post-holders and appropriate HR advice is being sought

Resource Implications

The approximate cost of a secondary care lead clinician is approximately £52,000 per annum for 4PAs

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The Cancer Alliance has national Service Development Fund monies and the funding for this is within our funding envelope.

Issues

Strategic alignment

The Long Term Plan sets a new ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients. In addition, the Alliance will be implementing the recommended Rapid Diagnostic Services and recently announced Community Diagnostic Hubs Much of this work will be undertaken in Primary Care and by strengthening our leadership in that setting and engaging with PCNs will be crucial in delivering this ambition and ambitions link to bowel and cervical screening.

The Long Term Plan also aims to develop safer and more precise treatments for cancer including advanced radiotherapy techniques and immunotherapies which will continue to support improvements in survival rates. Also, extending the use of molecular diagnostics over the next ten years and routinely offering genomic testing to all people with cancer for whom it would be of clinical benefit should translate into a survival benefit for patients.

Other recommendations in the Long Term Plan relating to cancer are:

- By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support and
- After treatment, patients will move to a follow-up pathway that suits their needs and ensures they can get rapid access to clinical support where they are worried that their cancer may have recurred.

By having strong leadership in secondary care and better links into the CAGs will allow the Alliance to drive these ambitions in a co-ordinated way

Risk analysis

There is a real risk that if we do not refocus and strengthen our clinical leadership in the hospital and out of hospital setting that the Alliance will not deliver on its transformational objectives and that we will be a further disconnection between our organisational leadership and our workforce.

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Appendix 1

Recurrent arrangements for SWAG Cancer Alliance Clinical Advisory Groups
http://www.swscn.org.uk/wp/wp-content/uploads/2019/09/Recurrent-Arrangements-for-SWAG-Cancer-Alliance-Clinical-Advisory-Groups-Final.pdf

Appendix 2

Priorities for Clinical leadership in the Recovery Phase

Priorities for clinical leadership	Activities	Solution
Radiology	Reduce variation in access to diagnostics and reporting time and quality. Implement image sharing. Support design of pathways that maximise productivity and are adequately resourced with radiology	Ensure links with Imaging network and relevant CAGs Establish short term SWAG-level group to oversee the implementation of image sharing
Clinical Data Science	Digitisation and transformation of cancer pathways cancer diagnostics, genomics, proteomics	Link effectively with Pathology Networks and Genomic services
Colorectal	Implement FIT pathway, supporting continuous improvement and system learning to evolve referral practice. Implementation of colon capsule, Endoscopy recovery	Drive though the colorectal CAG with links into primary care for the PCN DES
Lung	Restoring lung cancer referrals, implementation of NOLCP, Lung Health Check implementation.	Work through the Lung CAG and COG
Primary care	Engaging with PCNs to improve quality and experience of care throughout cancer pathway.	Use Out of Hospital Clinical Lead to link in with PCNs
Personalised Care	Support implementation of personalised care and support services	Work with the Personalised Care and Support Group to support implementation. Consider setting up a clinical board for prehab and rehab
Urology	Strong clinical leadership team have implemented a range of improvements in	Work through the Urology CAG and link in with the Urology Area Networks as

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	SWAG aimed at improving 62d performance. The priority now is to understand the reasons for the continued challenge and design pathways that can deliver consistent 62d achievement	appropriate
Rapid Diagnostic Centres and Community Diagnostic Hubs	SWAG RDS uptake has been limited by a lack of buy-in of system-wide model with systems interpreting the model in the context of their organisational limits and needs.	Work through the newly formed RDS steering Group to support implementation of services
Secondary Care	SWAG Clinical interface with CAGs to support delivery of LTP and recovery objectives. Supporting innovation in pathway development.	Appoint secondary Care clinical lead to support and drive this work
Inequalities	Increased system awareness of warranted and unwarranted variation in access to health care and development of strategies to address	Establish Early Diagnosis, Screening, Prevention and Inequalities Group. Develop strong links with Public Health

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