



SWAG Cancer Alliance Clinical Advisory Groups Terms of Reference

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1. Statement of Purpose

The Somerset, Wiltshire, Avon and Gloucestershire Cancer Network Clinical Advisory Groups¹ (CAG) endeavour to deliver equity of access to the best medical practice for our patient population. The essential priorities of the CAG are to provide a service that is safe, high quality, efficient and promotes positive patient experiences.

To ensure that this statement of purpose is actively supported, the essential priorities have been expanded to include ten key areas that are used to inform every CAG agenda, and the activities conducted within and outside the CAG meeting environment. Evidence to demonstrate that these are being achieved, or are in the process of being achieved, can be found on the CAG area of the SWAG website in the Constitutions, Clinical Guidelines, Work Programmes, Annual Reports, CAG meeting notes and corresponding meeting documents. The key areas are as follows:

1. The structure and function of the service is conducted, wherever possible, in accordance with the most up to date recommended best practice, as specified in the Quality Surveillance (formerly Peer Review) Cancer Service Quality Indicators
2. CAGs consisting of multidisciplinary professionals from across the Somerset, Wiltshire, Avon and Gloucestershire cancer services meet on a regular basis
3. Network wide systems and care pathways for providing coordinated care to individual patients are in place. This includes the process by which network groups link to individual MDTs
4. A process for ensuring that the CAG clinical decision making is in accordance with the most up to date NICE Quality Standards is in place, as are local clinical guidelines that support the standards
5. There is a process by which patient and carers can evaluate and influence service improvements that support the principle 'No decision about me without me'
6. Internal and externally driven routine risk related clinical governance processes are in place for evaluating services across the network and identifying priorities for improvement
7. CAGs have a coordinated approach to ensure that, wherever possible, clinical research trials are accessible to all eligible cancer patients
8. Examples of best practice are sought out and brought to CAGs to inform service development
9. Educational opportunities that consolidate current practice and introduce the most up to date practices are offered whenever resources allow

¹ Salisbury NHS Foundation Trust is partnered with the SWAG Cancer Alliance Board, but clinical teams participate in CAGs within the Wessex Cancer Alliance, and are therefore not part of this agreement.



10. Provision of advice to influence the funding decisions of the Cancer Alliance Board.

2. Organisation of CAGs

2.1 Organisers

Appendix I contains the list of groups that will be managed by the providers.

Acute provider members of the SWAG Cancer Alliances are responsible for employing a dedicated team to organise the majority of CAG meetings as detailed in Appendix II.

Providers are collectively responsible for the administration, governance and outcomes of the groups, ensuring that the groups are clear about their accountability and ability to influence services.

2.2 Chair

Nominations for the voluntary position of a CAG Chair must be supported by at least one other core member of the group. Where there is more than one nominee, the Chair of the group will be elected from within the membership of the Group.

The term of office will be between two to three years, unless otherwise agreed by the group members.

2.3 Frequency of meetings

The groups will meet at least twice a year.

A minimum of two months' notice will be given for all meeting dates.

2.4 Agendas

Agendas will be circulated one week prior to the meeting.

2.5 Reports

Reports will be produced for each meeting, capturing:

- Attendance
- Actions for group members
- Agreements
- Recommendations for providers/commissioners.

Draft reports will be circulated to the Chair within one month of the meeting.



2.6 Communication

The following documents will be made public on the South West Clinical Network Website:

- Meeting papers
- Agreed key documents
 - Clinical guidelines
 - Constitutions.

2.7 Quoracy of CAG

All participants at MDTs are welcome to attend the CAG meetings

Network group core membership to attend, with a minimum of one representative from each provider Trust:

Chair, MDT Core Members: Clinical Nurse Specialists, Surgeons, Physicians, Clinical Oncologists, Medical Oncologists, Imaging Specialists, Pathologists, Patient/User Representatives, Managerial and Administrative Support. Any other relevant Allied Health Professionals are welcome.

The Chair is to name a nominated network group member to be responsible for users' issues and information for patients / carers

The Chair is to name a nominated network group member responsible for clinical trial recruitment function.

3. Accountability

CAGs will be accountable to their respective Alliance Board, who will set the priorities and strategy for cancer within their geographical boundaries. CAGs should make commissioning decision requests via their Cancer Alliance Programme Manager, who will facilitate a collective commissioning response for the Alliance Board when necessary.

CAGs will also be accountable to their member providers.

4. Commissioning Requirements for CAGs

National Specialised Service Specifications require providers of specialised services to participate in clinical network groups.

Integrated Care Boards (ICBs) in the South West will require the same participation for CCG commissioned cancer services.

- Providers are jointly responsible for running CAGs and delivering the Quality Surveillance Programme requirements of the groups



- Individual providers are responsible for good attendance at CAGs and engagement with the work required outside the meetings.

5. Commissioner Responsibilities to CAGs

Commissioners will respond to issues raised by CAGs for services that they commission.

Commissioners will consult with CAGs on relevant issues.

6. Funding for CAG

Funding for CAGs will come from the providers as detailed in Appendix II.

The CA will support providers to seek sponsorship from the pharmaceutical industry for meeting the costs associated with running the groups. Providers need to satisfy themselves that any such funding complies with local governance arrangements.

The resources required to support CAG activity outside the meeting environment will come from those responsible for running them. This will require input from both senior clinicians (especially CAG Chairs) and provider MDT leads, but also Lead Cancer Nurses and Cancer Managers.

7. Quality Surveillance Programme (QSP, formerly Peer Review)

Individual providers are responsible for their own compliance with QSP, however, it is acknowledged that compliance (in part) relies on CAGs fulfilling their requirements and, in this respect, providers are jointly responsible for ensuring that CAGs fulfil these requirements.

Commissioners and the Cancer Alliance may request Peer Review visits to services that remain of concern.

Appendix I identifies the lead commissioner for each of the services.

8. Outcomes

The performance of the CAGs will be tested as follows:

- Attendance by core MDT members
- Performance of member organisations against agreed clinical outcomes and patient experience reports
- Performance in Quality Surveillance assessments
- Performance of member organisations in their own Peer Review
- Engagement of patients.



9. CAG Function

To support the CAG Statement of Purpose, the groups' provide expert clinical opinions on the following service activities on an ongoing basis when relevant:

Clinical opinion on network issues:

- Review of MDT workforce / meeting reforms / service reforms.

Clinical guidelines:

- Review of any amendments to imaging, pathology, systemic anti-cancer therapies, radiotherapy, surgical practices

Coordination of patient care pathways:

- Review hospital referral processes for TYA / varying indications / investigations and follow up
- Review implementation of Primary Care referral pro forma / implementation of rapid diagnostic pathways
- Cancer Waiting Times breach example to discuss.

Patient experience:

- User representative input
- Review of patient experience survey / identified actions
- Quality Of Life surveys
- Patient information
- CNS support
- Addressing inequalities.

Personalised Care and Support (formerly LWBC):

- Holistic needs assessments
- Next steps (Health and Wellbeing events)
- Treatment summaries.

Quality indicators, audits and data collection:

- Current audits against standards / audit outcomes
- Audits in the pipeline
- Data collection issues.



Research:

- Current clinical trials / recruitment / actions to improve recruitment
- Clinical trials in the pipeline
- Developing early career researchers / addressing inequalities

Service development:

- Early diagnosis
- Prehabilitation / enhanced recovery programme
- Training opportunities available
- Sharing best practice
- Awareness campaigns.

Quality Surveillance Programme:

- To undertake work to satisfy Quality Surveillance requirements, including:
 - Constitution
 - Work Programme review
 - Good practice – specific areas to highlight
 - Are there immediate risks?
 - Are there serious concerns?

10. Reporting Processes

10.1 Local Resolution

Issues of concern raised by a CAG and agreed to be a local operational issue, will be referred in the first instance to the relevant provider trust/s, via the Cancer Services Manager/Lead Cancer Nurse for local resolution.

10.2 Escalation

Issues raised by CAG which require input from the relevant ICB will be directed to the SWAG Cancer Alliance Delivery Group for discussion. If the Cancer Clinical Advisory Group Manager is unable to resolve the issue, additional communication may be required by a CAG representative/Chair communicating with or attending the Delivery Group.

Issues relating to Specialist Services Commissioning will be escalated where appropriate to the SWAG Cancer Clinical Lead.



11. APPENDICES

11.1 Appendix I

Responsibilities for Cancer Alliance CAGs

Site Specific	Lead Commissioners for Service	Responsibility for supporting Groups ²
Acute Oncology	ICBs	Cancer Alliance
Brain/CNS	Specialist Commissioning (SC)	Providers
Breast	ICBs	Providers
Colorectal	ICBs	Providers
Gynae-Oncology/SWAGGER	SC	Providers
Haematological Malignancies	ICBs	Providers
Head and Neck	SC	Providers
Hepato-Pancreato-Biliary	SC	Providers
Lung	ICBs	Providers
Non-Site Specific	ICBs	Cancer Alliance
Oesophago-Gastric	ICBs	Providers
SACT	ICBs	Providers
Skin	ICBs	Providers
Soft Tissue Sarcoma	SC	Providers
SWIG	ICBs	Providers
Urology (including testicular/penile)	ICBs	Providers

Service Specific	Lead Commissioners for Service	Responsibility for supporting Groups
Cancer Early Diagnosis	ICBs	CA
Chemotherapy	SC	Providers
Children and Young People	SC	Operational Delivery Network
Radiotherapy	SC	Operational Delivery Network



1.2 Appendix II

SWAG Cancer Alliance Clinical Advisory Group Service Level Agreement

The costs and share of running CAGs is to be determined by the provider members. Details can be found in the Service Level Agreement which is available on request.

The SWAG Cancer Alliance will reimburse Provider Trusts for their financial contribution from April 2020-2025/26. Details can be found in the Memorandum of Understanding which is available on request.

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